United Food and Commercial Workers Lo. Union 1529
and Employers Health and Welfare Plan & Trust ("The Plan")

661 N. Ericson Rd., Cordova, TN 38018 • Toll Free: 1·800·874-8499 • Fax: 1·901-758-3021

SPOUSE SURCHARGE WILL BE EFFECTIVE JANUARY 1, 2021

Employees may choose to have their spouse covered under the Plan; however, there will now be a required monthly payment requirement (a surcharge) that will apply for those spouses who have access to other employer sponsored coverage but who still wish to enroll in coverage under this plan. **EMPLOYEE SPOUSES WHO HAVE ACCESS TO OTHER COVERAGE WILL ONLY BE ELIGIBLE FOR SECONDARY COVERAGE UNDER THIS PLAN SUBJECT TO ALL APPLICABLE CONTRIBUTIONS.** In order for your spouse to have full coverage, they will need to enroll in their own employer sponsored plan.

Employees with spouses who do not have access to other employer sponsored coverage are exempt from the $150.00 (per month) payment requirement upon execution of the below required spousal affidavit. In addition, employees with spouses working for Kroger will also be able to waive this contribution.

The spouse surcharge will be deducted automatically from your paycheck if you have a spouse covered under your medical plan. To make a change due to a qualifying life event, your will have 30 days from the date of the qualifying event to make sure election.

To be completed by you, the Member of this Plan

Spouse's Name:

Spouse's Employer (Company Name):

Spouse's Social Security#:

Is your spouse employed?	☐ Yes	☐ No
Is your spouse self-employed?	☐ Yes	☐ No

Effective date your spouse retired or became unemployed:

If your spouse has coverage available through his/her employer:

☐ My spouse has elected coverage through his/her employer. I elect to pay the Working Spouse Fee of $150 per month. I consent to having this fee collected by my employer via payroll deduction and I understand this Fund will provide secondary coverage.

☐ My spouse has declined coverage through his/her employer. I elect to pay the Working Spouse Fee of $150 per month. I consent to having this fee collected by my employer via payroll deduction. I understand that this Fund will provide secondary coverage for my spouse.

If your spouse is not employed or does not have coverage available through his/her employer:

☐ My spouse is unemployed or has no health coverage available through his/her employer. I understand that this Fund will provide primary coverage for my spouse.

Name Spouses Company:	**Name of Spouses Insurance:**

Effective Date of Spouses Insurance:

Phone Number of above Owner or Benefits/HR Administrator:

I hereby certify that the information provided is correct. I understand that any misrepresentation in the information I have provided above will permit UFCW Local 1529 and Employers Health & Welfare Plan & Trust to terminate the spouse coverage and seek any other legal remedies available including possible prosecution for fraud. If applicable, I authorize the release of the health care plan coverage information requested below and authorize its use in the application for coverage under UFCW Local 1529 and Employers Health & Welfare Plan & Trust. I also understand that if my spouse becomes eligible for medical coverage from his or her employer during the plan year I must notify the Plan Administrator. I understand if my spouse is/was eligible through their employer and I have not been charged the applicable surcharge, I will be responsible for all charges for the amount of time my spouse was covered and eligible under their employer's plan.

Employee Signature:

Date: