Employed Spouse Coverage Affidavit

Important: please ensure this form is fully completed.

Your response, or lack of response, will impact your spouse's health care coverage.

SECTION 1: Pipefitter and Spouse Information

Pipe Fitter Name:	Full Name of Spouse:
Pipe Fitter Date of Birth:	Phone Number:
Address:	

Was your spouse employed on January 1, 2024? Yes ☐ No ☐

- **If the answer is Yes, then complete the box below.**
- **If the answer is No, then you do not need to complete the rest of the Affidavit.**

Is your spouse eligible for Qualifying Health Coverage from his/her employer as of March 31, 2024?

- ☐ **Yes,** my spouse has Qualifying Health Coverage available from his/her employer as of March 31, 2024, and my spouse will enroll in such coverage by April 1, 2024.
- ☐ **Yes,** my spouse has Qualifying Coverage available from his/her employer as of March 31, 2024, but my spouse will not enroll in such coverage by April 1, 2024. I understand at 11:59 p.m. on March 31, 2024, my spouse will no longer have coverage from the Pipefitters Local No. 533 Health and Welfare Plan.
- ☐ **No,** my employed spouse does not have Qualifying Health Coverage available from his/her employer as of March 31, 2024.

If you checked the third box, then your spouse's employer MUST complete Section II of this Affidavit. If you checked the first or second box, then neither you nor your spouse's employer need to complete Section II of this Affidavit.

SECTION II: Employer Certification of Spouse's Health Insurance Coverage

Note: this section must be completed in full by your Spouse's employer

1. Does your company/organization offer health insurance to your employees that is designed to satisfy minimum essential health coverage requirements under the Affordable Care Act?
   ☐ Yes ☐ No ***If the answer to #1 is yes, please proceed to #2. If no, please go to #5.***
2. As of **March 31**, 2024, is the Spouse named above eligible for your company/organization's health insurance coverage?
   ☐ Yes ☐ No ***If the answer to #2 is yes, please proceed to #4. If no, please go to #3.***
3. Why is the Spouse named above not eligible for your company/organization's health insurance coverage as of March 31, 2024?

   ☐ The Spouse is not a full-time employee company health insurance coverage offered to part-time employees. **(if checked, proceed to #5)**

   ☐ The Spouse is in a waiting period until (date): _____ **(if checked, proceed to #5)**

   ☐ The Spouse did not enroll during the Open Enrollment Period. **(if checked, proceed to #4)**

   ☐ Other: _____ **(if checked, proceed to #4)**

4. What is the employee's cost for the least expensive employee-only coverage option available (excluding any voluntary coverage buy ups, e.g., vision, dental, etc.)? $_____per_____. **Please complete #5.**

5. Employer Information:
   Name of employer: _____ Phone: _____

   Address of employer: _____

   Name of Representative (printed) _____Title: _____
   Signature of Representative: _____ Date: _____

Participant signature: _____ **Date:** _____