

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, 2026? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<ul style="list-style-type: none">• If the answer is Yes, then complete the box below.• If the answer is No, then please sign, date and return the Affidavit to the Benefit Office.	
Is your spouse eligible for Qualifying Health Coverage from his/her employer as of March 31, 2026?	
<input type="checkbox"/> Yes, my spouse has Qualifying Health Coverage available from his/her employer as of March 31, 2026, and my spouse will enroll in such coverage by April 1, 2026.	
<input type="checkbox"/> Yes, my spouse has Qualifying Coverage available from his/her employer as of March 31, 2026, but my spouse will not enroll in such coverage by April 1, 2026. I understand at 11:59 p.m. on March 31, 2026, my spouse will no longer have coverage from the Pipefitters Local No. 533 Health and Welfare Plan.	
<input type="checkbox"/> No, my employed spouse does not have Qualifying Health Coverage available from his/her employer as of March 31, 2026.	
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 2: Employer Certification of Spouse's Health Insurance Coverage

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

- 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.*
 - As of **March 31, 2026**, 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.*
 - Why is the Spouse named above not eligible for your company/organization's health insurance coverage as of March 31, 2026?
 The Spouse is not a full-time employee and company health insurance coverage is only offered to full-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)*
 - 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.**
 - Employer Information:
Name of employer: _____ Phone: _____
Address of employer: _____
Name of Representative (printed) _____ Title: _____
Signature of Representative: _____ Date: _____
- Participant signature:** _____ **Date:** _____