MICHIGAN ELECTRICAL EMPLOYEES' HEALTH PLAN

SPOUSE EMPLOYMENT DATA FORM

(ALL MARRIED PARTICIPANTS MUST SUBMIT THIS FORM WITH SIGNATURE OF EMPLOYEE AND SPOUSE)

SECTION I: INFORMATION ABOUT PARTICIPANT

Full Name: ______________________________ Phone: ____________________

MID or SS #: ______________________________ Cell #: ____________________

Address: ______________________________

______________________________ New address and/or phone

SECTION II: INFORMATION ABOUT SPOUSE

Full Name: ______________________________

SS #: ______________________________

Employment Status: (check one) Not Employed Employed Full-time (30 or more hours per week)) Employed Part-time (0-29 hours per week) Self-employed Retired

SECTION III: INFORMATION ABOUT SPOUSE'S EMPLOYMENT

Company Name: ______________________________ Contact: ____________________

Address: ______________________________ Phone: ____________________

______________________________ Date of Hire: ____________________

Does employer offer a healthcare plan for its employees? YES NO
Is spouse eligible to enroll in employer's healthcare plan? YES NO
Is spouse enrolled? YES NO
If your spouse is ineligible for coverage for some reason other than because she works part-time, you must submit a letter from the employer on company letterhead that explains the reason for your spouse's ineligibility by October 31, 2012.
If not enrolled, when is the spouse's next enrollment opportunity? ____________________

When would coverage begin? ____________________

SECTION IV: INFORMATION ABOUT SPOUSE'S INSURANCE THROUGH EMPLOYMENT (You may attach a photocopy of both sides of medical ID card or fill out below.)

Insurance Company or Plan Name: ______________________________

Address: ______________________________

Group #: ____________________ Individual ID #: ____________________

Check all that apply: Major Medical PPO High Deductible HSA HMO Single Coverage Family Coverage Other (explain)

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SECTION IV: EMPLOYEES' AND SPOUSE'S SIGNATURE

I affirm that the information given on this form is true and correct to the best of my ability. I understand that if I have given false information or made any material misrepresentations in response to the questions on this form, it could result in a loss of coverage and/or penalties, fines and prosecution.

Employee's Signature ______________________ Date ____________

Spouse's Signature ______________________ Date ____________

SECTION VI: SPOUSE'S SIGNATURE (AUTHORIZATION TO RELEASE INFORMATION)

I hereby voluntarily authorize my employer to release information regarding my employer's health plan, including, but not limited to, information about my eligibility for coverage, benefits provided by my employer's plan, enrollment requirements, my hours worked per week, wages and employee premium co-pay amount under that plan to the Michigan Electrical Employees' Health Plan (MEEHP). This authorization shall remain in effect as long as I am eligible for benefits under MEEHP. I understand that after this information is disclosed to MEEHP, MEEHP might re-disclose it. I understand the purposed of this authorization is to allow MEEHP to obtain information it needs to make an eligibility or enrollment determination. I understand that my failure to obtain such information from my employer could result in termination of my coverage under the MEEHP. I understand that I am entitled to receive a copy of this authorization. A photocopy, facsimile or PDF copy of this signed authorization shall be considered as valid as an original signed copy. I understand that I have the right to revoke this authorization at any time by notifying MEEHP in writing and the revocation is only effective after it is received by the Plan. Prior disclosures before the revocation are not affected.

Spouse's Signature ______________________ Date ____________

Submit to the Plan Office: Michigan Electrical Employee's Health Plan, 3001 Metro Dr. Suite 500, Bloomington, MN, 55425