NECA/IBEW FAMILY MEDICAL CARE PLAN
410 Chickamauga Avenue, Suite 301
Rossville, GA 30741
http://www.NIFMCP.com

Phone (706) 841-7000 Fax (706) 841-7020 Toll Free (877) 937-9602

ENROLLMENT FORM

COMPLETE AND RETURN TO YOUR EMPLOYER

Name of Employee _____ Soc. Sec. No. _____

Address _____
(street number and street name)

_____ Telephone No. ( ) _____
(city, state, zip code)

Local Union No. _____ Current Employer _____
(name, city, state, zip code)

Coverage Election: (circle one) **Employee Only** **Employee+Spouse** **Employee+Children** **Family**

Date of Birth _____ Sex: M F (circle one) Marital Status: Single Married/Date_____ Div Sep Legally Sep Widowed (circle one)

Name of Spouse _____ Date of Birth _____ Soc. Sec. No _____

Name of any family member through which other group coverage is provided _____

Name, address, telephone no., and group/member I.D.s for that health plan _____

_____

List all dependent children under age 26 (If you have chosen Employee+Children or Family Coverage)

Full Legal Name	Relationship to you (natural child, step-child, etc.)	Does child live with you?	Child's Social Security Number	Date of Birth	Sex
1.					
2.					
3.					
4.					
5.					
6.					

FOR ANY NEWLY ENROLLED CHILD LISTED ABOVE, PLEASE SUBMIT A CERTIFIED BIRTH CERTIFICATE OR COPIES OF ALL PERTINENT COURT ORDERS (DIVORCE DECREES, CUSTODY AWARDS, PATERNITY ORDERS, ETC.).

LIFE INSURANCE BENEFICIARY

Designate one or more beneficiaries for your Life Insurance and AD&D Insurance benefits.

Primary Beneficiary(ies):

Full Legal Name	Relationship to You	Social Security Number	Date of Birth	% of total (must equal 100%)

Contingent Beneficiary(ies) - Insurance benefits will only be paid to a contingent beneficiary if there is no surviving primary beneficiary:

Full Legal Name	Relationship to You	Social Security Number	Date of Birth	% of total (must equal 100%)

The above-named beneficiary supersedes any and all beneficiaries previously designated. Designation of a beneficiary on this form will be valid only if the Fund Office receives this form while you (the employee) are still living.

_____ _____

Date Signed **Employee Signature**

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NECA FMCP
Family Medical Care Plan

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SPOUSE EMPLOYMENT DATA FORM 2020

➡ **YOU AND YOUR SPOUSE MUST SIGN WHERE INDICATED BELOW.**

1. EMPLOYEE INFORMATION.

1. Full name _____ SSN or Card ID# _____
2. Address _____
3. Email Address: _____ Cell Phone No. _____
4. Marital status: ☐ single ☐ married ☐ divorced ☐ other (explain) _____

2. SPOUSE INFORMATION.

1. Full name of spouse _____ Spouse's SSN _____
2. Spouse's employment status: ☐ not employed ☐ employed full-time ☐ employed part-time ☐ self-employed ☐ retired
3. Name of spouse's employer _____ Date of Hire _____
4. Contact person and telephone number at spouse's employer _____
5. Does spouse's employer offer a healthcare plan for its employees? ☐ Full Time ☐ Part Time ☐ No
6. Is spouse eligible to enroll in employer's healthcare plan? ☐ yes ☐ no 7. Is spouse enrolled? ☐ yes ☐ no

WORKING SPOUSE RULE: This Plan requires that your spouse enroll in his or her employer's health plan. If your spouse fails to enroll, this Plan will reduce its benefits to 20% of covered charges. If you fail to complete this form his or her coverage will be terminated. If your spouse's employer offers health coverage but your spouse is not eligible to participate, you must submit a letter from the employer on company letterhead that explains the reason for his or her ineligibility.

- ***If your spouse's employer does not offer Medical Insurance you must provide a letter on company letterhead confirming that the Medical Benefits are not offered.***

There is a hardship exemption to the working spouse rule for spouses earning: a) less than $23,000 per year; or b) between $23,000 and $35,000 per year if the coverage costs your spouse more than $200 per month.

Answer No. 8a and 8b below ONLY if you want to claim the hardship exemption. A letter attesting to wages and cost of coverage MUST BE PROVIDED from the employer on company letterhead. (W2s and Check Stubs are NOT acceptable)

8a. Annual salary (for current calendar year) _____ 8b. Monthly Insurance Premium _____

9. If not enrolled, when is spouse's next enrollment opportunity? _____ When would coverage begin? _____

Answer the following questions if spouse is enrolled in his or her employer's healthcare plan.

10. Has the Insurance Plan changed since the last enrollment period? ☐ yes ☐ no 12. If so, what is the effective date? _____
11. What was the termination date of prior coverage? (Please include a copy of the Letter of Creditable Coverage) _____
12. Provide the name of the insurance company/plan (or attach a photocopy of both sides of medical ID card) _____

_____

13. Plan information: Group No. _____ Individual ID No. _____
☐ single coverage ☐ family coverage ☐ other (explain) _____

3. SIGNATURES.

EMPLOYEE'S SIGNATURE

I affirm that the information given on this form is true and correct to the best of my ability.

➡ _____ _____
Employee's Signature Date

SPOUSE'S SIGNATURE (AUTHORIZATION TO RELEASE INFORMATION)

I hereby authorize my employer to release information regarding my employer's health plan, and my eligibility for coverage under that plan to the NECA/IBEW Family Medical Care Plan (FMCP). This authorization shall remain in effect as long as I am eligible for benefits under the FMCP. I affirm that the information provided on this form is true and correct to the best of my ability.

➡ _____ _____
Spouse's Signature Date

4. SUBMIT TO FUND OFFICE. Mail completed form to the FMCP at 410 Chickamauga Ave Suite 301, Rossville GA 30741. Or fax to (706) 841-7020