Welfare Fund
of Local No. One, I.A.T.S.E.

320 West 46th Street, 6th Floor ● New York, NY 10036 ● Tel (212)247-5225 ● Fax (212)977-9319 ● www.fundoneiatse.com

March 14, 2018

Please respond by **May 31, 2018**
to avoid a **July 1, 2018** suspension of your
spouse's medical coverage.

Dear Welfare Fund Participant:

As a participant in the Welfare Fund who has elected medical coverage for your spouse, you are required to fill out and return the attached *Spousal Coverage Confirmation* form to the Fund Office no later than **May 31, 2018**. If you fail to fill out and return the attached Spousal Coverage Confirmation form by May 31, 2018, your spouse's coverage will be suspended effective **July 1, 2018**.

The Board of Trustees is requiring this confirmation because there have been past incidents in which participants failed to remove their spouse after a divorce or legal separation. In such situations, the Fund Office will eventually become aware of the divorce or separation when the participant wishes to retire or change beneficiaries and must provide the divorce documents. At that point, the ex-spouse may have incurred considerable claims expense, which the Fund should have never paid. This is a fraud which hurts the Plan, and by extension, all the other participants in the Plan.

Please note that on page 11 of the SPD you are required to provide prompt notice to the Fund Office if you and your spouse legally separate or divorce. If you fail to inform the Fund Office of such legal separation or divorce, the Fund may hold you **legally responsible** for all costs associated with extending coverage to your spouse after your legal separation or divorce became final. This may include the full premium expense for such coverage and the full cost of all claims expense incurred after the legal separation or divorce.

Again, failure to remove a former spouse from your health insurance coverage is enrollment fraud. As such, the Trustees also have the right to terminate your Fund coverage and that of your other covered family members for failure to provide timely notice of a legal separation or divorce from a covered spouse.

Please call the Fund Office at (212) 247-5225 if you have any questions.

Sincerely,

Scott Cool
Director of Fund Administration

Welfare Fund of Local No. One, I.A.T.S.E.

Spousal Coverage Confirmation

Please complete this form **ONLY** if you have elected medical coverage for your spouse

Each participant who has elected medical coverage for his or her spouse must complete the following information. This initiative is intended to ensure that each spouse covered under the Plan is accurately listed and eligible for coverage. Each participant must certify that the person listed below is his or her spouse and that they are not legally separated or divorced. Please make sure that you have provided all of the information requested below. If you fail to fill out and return this Spousal Coverage Confirmation form by May 31, 2018, your spouse's coverage will be suspended effective July 1, 2018.

Employee Name: _____ Last four digits of SSN: ___ ___ ___ ___

Spouse name: _____ Last four digits of SSN: ___ ___ ___ ___

I hereby certify that my spouse and I are currently married and not legally separated. ☐ Yes ☐ No

Participant Acknowledgement of Responsibility:

I have read the above information regarding the spouse requirement for health insurance coverage under the Plan. I have also read the Plan eligibility requirements in the SPD. I acknowledge that the information on this form is accurate to the best of my knowledge. I understand that if any false statement is made or information withheld, the Trustees of the Welfare Fund of Local No. One, I.A.T.S.E. will hold me legally responsible for all costs associated with extending coverage to my spouse after our legal separation or divorce became final. This could include the full premium expense for such coverage and the full cost of all claims expense incurred after the legal separation or divorce. I also understand that any false statement made or information withheld could result in the immediate termination of my health insurance coverage and the health insurance coverage of my other dependents.

Participant Signature: _____

E-mail Address: _____

Phone Number: _____