CONSTRUCTION INDUSTRY WELFARE FUND ROCKFORD, ILLINOIS
SPOUSE INSURANCE COVERAGE INFORMATION
This form MUST be completed if you are a working spouse of a Construction Fund member.

MEMBER INFORMATION (To be completed by employee and spouse)

Construction Industry Welfare Fund of Rockford, Illinois Member's Name: _____ SSN# _____

Spouse's Name: _____ SSN# _____

Is Spouse Employed: YES _____ Member and spouse to sign below and continue on to Part II.
NO _____ Member to sign below and return form.

MY SPOUSE'S EMPLOYMENT AND COVERAGE IS THE SAME AS LAST YEAR, NO CHANGES. YES _____
Please sign below and return.

Member's Certification: **I certify that the above information is correct and that I understand my responsibility to notify you of any changes. I understand that if my spouse is eligible to participate in his or her employer-sponsored group health insurance plan, and the employer contributes 50% or more of the single coverage premium, should my spouse not enroll, that my spouse will NOT be eligible for coverage under the Fund's Plan.**

Construction Industry Welfare Fund of Rockford, Illinois Member's Signature Date

Spouse's Authorization to Release Information: I herby authorize my employer to release the information requested below to the Construction Industry Welfare Fund of Rockford, Illinois or its claims administrator, for the sole purpose of ascertaining eligibility for enrollment in my employer-sponsored plan.

Spouse's Signature Date

PART II INFORMATION ON SPOUSE'S PLAN (To be completed by spouse's employer)

Your Employee's Name _____
Last, First, MI

	MEDICAL		DENTAL	
	YES	NO	YES	NO
Is employee eligible for your employer-sponsored group health insurance plan?	___	___	___	___
Is this employee currently enrolled in your plan?	___	___	___	___
Do you, the employer pay at least 50% of the single coverage premium? (In cash or as part of a Cafeteria Plan?) For example, if your single coverage cost is $1,000 per year, do you pay $500 or more of the cost?	___	___	___	___

If the employee is NOT currently enrolled in your plan, Special Enrollment is required and effective: _____
Month/Day/Year

Comments: _____

Employer Name/ _____ Insurance Carrier Name/ _____
Address: _____ Address: _____
_____ _____
Telephone: _____ Policy #: _____
Group #: _____

Completed by: _____
Signature Date
_____
Signature Date

Return form to Group Administrators, Ltd., 1322 E State Street, Suite 300, Rockford, IL 61104. Questions? Call GAL at (815) 399-0800 Fax (847) 519-1979.