I.B.E.W. LOCAL UNION NO. 43 AND ELECTRICAL CONTRACTORS
WELFARE FUND
P.O. Box 2218
Syracuse, New York 13220-2218

SPOUSAL AFFIDAVIT

Participant/
Member
Name _____ SS#_____
Last First MI

Phone
Home Address_____ Number_____

_____

_____

I, _____, am the spouse of the above-named participant, a member of
(Name of Spouse)
I.B.E.W. Local Union No. 43. I submit this affidavit in connection with the Welfare Fund's "Working Spouse Rule".

I certify that: (Check the appropriate box below)

☐ 1. I am not presently employed.

☐ 2. I am presently employed but am not eligible to receive health insurance benefits through my employer or my employer does not provide health insurance benefits to its employees. **YOU MUST ATTACH A LETTER FROM YOUR EMPLOYER WHICH CONFIRMS THIS STATEMENT.**

☐ 3. I am presently employed and am eligible to receive health insurance benefits through my employer. However, my employer does not contribute to the cost of the health insurance or contributes less than 50% of the cost of the health insurance. **YOU MUST ATTACH A LETTER FROM YOUR EMPLOYER CONFIRMING THIS STATEMENT.**

☐ 4. I am presently employed and am eligible to receive health insurance benefits through my employer. My employer contributes at least 50% of the cost of the health insurance on my behalf.

-PLEASE COMPLETE OTHER SIDE-

If you checked Item No. 1, 2, or 3 above, you do not need to complete the next section of this form. If you checked item 4 above, please complete the following:

EMPLOYER INFORMATION

Name of Employer _____
Employer's Address _____
_____
Telephone No. _____ Fax No. _____

Please check the appropriate box below:

☐ 1. I do not participate in my employer's health insurance plan. I understand and agree that I am not eligible for benefits from the International Brotherhood of Electrical Workers Local No. 43 and Electrical Workers Welfare Fund.

☐ 2. I am enrolled in my employer's health insurance plan. (**YOU MUST PROVIDE PROOF OF YOUR COVERAGE UNDER THE HEALTH INSURANCE PLAN SUCH AS THE INSURANCE POLICY AND/OR INSURANCE CARD.)** I understand that the coverage through my employer shall be primary and that coverage under the International Brotherhood of Electrical Workers Welfare Fund shall be secondary pursuant to the coordination of benefits provisions of the Plan.

I hereby certify that the statements and information set forth above are true and accurate.

Signature: _____ Date_____

Print Name: _____

Sworn to before me this
_____ day of _____, 20___.

_____
Notary Public