New England Health Care Employees
WELFARE FUND

77 Huyshope Avenue, 2nd Floor
Hartford, CT 06106-7001
860/728-1100 Fax 860/947-8080

SPECIAL ENROLLMENT FOR COVERED SPOUSES

Dear Participant:

The Welfare Fund Board of Trustees adopted a plan change, effective January 1, 2020, that the Welfare Fund will no longer provide health coverage to spouses of active participants that are currently employed and have health coverage available to them through the spouse's own employer. However, if your spouse does not have coverage available to them through their own employer or are disabled you may enroll them with the Welfare Fund.

To be eligible for spousal health coverage the criteria (below) must be met:

- Complete the enclosed "***Special Enrollment***" Form
- If your spouse is currently employed, please have your spouse's employer complete the form titled "***Spouse's Employer Affidavit***".
- If your spouse is not employed, your spouse must complete the "***Affidavit in lieu of employment verification***" form (this form must be notarized), in addition, a copy of you and your spouse's (last year) tax return is required.
- If your spouse is disabled, they will need to supply a copy of the Social Security Disability Award and a copy of their Medicare card.
- Submit a check or Money order for the spousal $250.00 monthly premium.

Your payment is due by the 1st of every month. Please make checks payable to New England Healthcare Employees Welfare Fund or NEHCWF for short. Refer to ***Welfare Fund payment options*** for ways to pay your spousal and COBRA payments.

Due to COVID-19, the Fund will accept scanned/faxed copies of the above. ***Failure to complete the forms or provide the Welfare Fund with the required documents will result in delaying your spouse's effective date for coverage***. Your spouse's coverage does not begin until you return all required documents and pay the spousal $250.00 monthly premium.

If you have any questions about the Special Enrolment or the other forms, please call the Membership Department at 860-728-1100 or 1-800-227-4744.

New England Health Care Employees
WELFARE & PENSION FUND

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Hartford, Connecticut 06106-7001
Phone: 1-800-227-4744 Fax: 1-860-947-8080

SPECIAL ENROLLMENT FORM FOR COVERED SPOUSES

PLANILLA DE INSCRIPCION

YOU MUST ANSWER ALL QUESTIONS AND PRINT CLEARLY IN INK
(THIS FORM IS STRICTLY CONFIDENTIAL)

DEBE CONTESTAR LAS PREGUNTAS CLARAMENTE EN TINTA Y CON LETRA DE MOLDE
(ESTA PLANILLA ES ESTRICTUMENTE CONFIDENCIAL)

INSTRUCTIONS FOR FILLING OUT THE SPECIAL ENROLLMENT FORM FOR SPOUSES ONLY:

Instruciones para rellenar la Planilla especial para los esposos(as) Solamente:

- Special enrollment form should be completed with Spouse's information for ***sections (1 & 2)***, not employee.
- *La planilla especial tiene que ser completada con informacion de los esposos(as), no los empleados.*
- The entire form must be filled out to be accepted. Any missing information will result in a delay with your Health Insurance benefits if you are eligible to receive these benefits.
- *La planilla completa tiene que ser rellenado para poder ser aceptado. Cualquier informacion incompleta retrazara los beneficios de Seguro si Ud. es elegible para estos beneficios.*
- Please mail or fax all required documents together.
- *Por favor envie todos los documentos requeridos por correo o por fax.*

PARTICIPANT INFORMATION *La informacion de identificacion personal*

Participant Name (Last, First, Middle Initial) *Nombre del Miembro*	ID#/SS#
Home Telephone *Area y No. de telefono* ( )	Email Address *direccion de correo electronico*

1- SPOUSE'S INFORMATION *Informacion personal de su esposo(a)*

Spouse's Name (Last, First, Middle Initial) *Nombre del esposo(a)*			Social Security *Seguro Social*	
Current Street Address *Domicilio*		City *Ciudad*	State *Estado*	Zip *Zona Postal*
Home Telephone *Area y No. de telefono* ( )	Date of Birth Fecha de Nacimiento	Sex *Sexo*	Marital Status *Estado Civil* Single □ Married □ Separated □ Divorced □	

2- EMPLOYMENT INFORMATION FOR SPOUSE ONLY *Escriba la informacion de su empleador*

Name of Employer *Lugar de trabajo actual*		Work Telephone *Telefono del trabajo* ( )	
Employer Street Address *Direccion de su empleador*	City *Ciudad*	State *Estado*	Zip *Zona Postal*

- **You must provide all required documentation. Failure to provide all documents will result in denial of spousal coverage.** *Debe proporcionar toda la documentación requerida. El hecho de no proporcionar todos los documentos dará lugar a la negación de la cobertura medica a su esposo(a).*

THE FORGOING STATEMENTS ARE TO THE BEST OF MY KNOWLEDGE TRUE AND COMPLETE.

La declaracion anterior es totalmente cierta y es hecha en pleno ejercicio de mis facultades fisicas y mentales.

Spouse's Signature *Firma de esposo(a)* **X**_____ Date *Fecha* _____

Participant's Signature Firma Participante X_____ Date Fecha_____

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Spouse's Employer Affidavit

Participant Name: _____ ID # NET _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer Name_____

Employer's Address_____
Street Name City State Zip Code

Telephone Number_____

I certify that _____does not offer Health Insurance to
Name of Employer

_____.
Employee Name

_____ _____

Employer Representative's Signature Date Employer Representative's Name (Print) Title

Participant's Signature_____Date_____

Spouse's Signature_____Date_____

Participant ID#: NET

New England Heath Care Employees Welfare Fund

AFFIDAVIT IN LIEU OF EMPLOYMENT VERIFICATION

I, _____, being duly sworn, hereby depose and say:

1. **I am NOT employed, or**

2. **I am self-employed.**

3. **If my status changes, I will notify the Welfare Fund immediately.**

4. **I understand that the Welfare Fund will rely on the accuracy and truthfulness of this affidavit, and I agree to reimburse the Welfare Fund for any benefits paid as the result of any inaccuracy or misstatement in this affidavit.**

Signature: _____

Date: _____

Print

Name: _____

Address: _____

_____

STATE OF CONNECTICUT

COUNTY OF _____

Personally appeared _____ and made oath to the truth of the matter contained in the foregoing Affidavit before me this ____ day of _____, 20____.

_____

Notary Public

My Commission expires:

New England Health Care Employees
99 WELFARE FUND

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Welfare Fund Payment Options

There are a couple of ways in which you can pay your monthly COBRA payments and Spousal Payments to the New England Health Care Employees Welfare Fund. We accept personal checks, money orders and bill payment checks issued directly from your bank. The Fund does not accept any cash or credit card payments. To make sure there is no interruption of your health coverage, your payment should arrive at the Fund Office prior to the 1st day of the month. For example, if you are paying for January coverage, your check should be at the Fund no later than December 31st to ensure that there is no interruption in your health coverage.

**** IMPORTANT ** Please include your ID number with your payment.**

1. You can write a personal check or get a money order made payable to the New England Health Care Employees Welfare Fund of (N.E.H.C.E.F.) The address to remit payment is: New England Health Care Employees Welfare Fund, 77 Huyshope Ave., 2nd Floor, Hartford, CT 06106.

2. You can contact your bank to set up an automatic (or one-time) bill-payment from your account. If you normally pay your bills using your bank's bill-payment feature, then you can add the New England Health Care Employees Welfare Fund (N.E.H.C.E.F.) as a "new Payee". You have the option to set this up as a one-time payment or schedule monthly reoccurring payments. You would need to set the dollar amount up (either COBRA amount if on COBRA or the spousal monthly payment of $250 if your spouse is eligible for coverage under the plan). If you choose to have automatic/reoccurring payment's you can select the date that you would like your bank to issue the checks and that would also be the date the bank debits the money from your account (please allow 7-10 days for your bank to issue the check and allow for mail handling time).