EASTERN ATLANTIC STATES
CARPENTERS BENEFIT FUNDS
WWW.CARPENTERS.FUND

New Jersey Location: 91 Fieldcrest Ave. Suite 25
Edison, NJ 08837 - (732) 417-3900

Philadelphia Location: 1811 Spring Garden St.
Philadelphia, PA 19130 - (215) 568-0430

2025 SPOUSE EMPLOYMENT VERIFICATION FORM

Participant Name: _____ UBC # or Last Four of SSN:_____

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

1. Spouse's Employment Status

☐ Not employed ☐ Retired ☐ Medicare

☐ Self Employed - Name and type of business _____

☐ Employed **(If you have included a copy of your Insurance Cards, your Employer does not need to complete the Employer Section below.)**

2. Employer Section (If Applicable)

Employee Name _____

☐ Employee is currently in a Waiting Period. Employee will be eligible: _____

☐ Employee did not elect to enroll in Health Benefits. Next Open Enrollment period:_____

☐ Employee works 30 hours or less a week and is not eligible for benefits.

☐ Health coverage is offered, but without contributions toward the premium cost.
(Must submit cost of insurance and most recent paystub)

☐ Health Coverage is not offered. Please Explain: _____

Employer Name:_____

I hereby certify the person stated on this form is an Employee and the information above is accurate and complete to the best of my knowledge.

Employer Representative Signature and Name Printed: _____

E-Mail: _____ Phone Number: _____

PARTICIPANT/SPOUSE AUTHORIZATION AND SIGNATURES (IN ORDER FOR THIS FORM TO BE COMPLETE, BOTH MUST SIGN)

We hereby declare under penalty of perjury that we are legally married and the information on this form is correct and complete to the best of our knowledge. We authorize the Eastern Atlantic States Carpenters Health Fund to verify the spouse's employment status as needed. If requested by the Fund, we agree to obtain and furnish a copy of any marriage certificate, divorce decree, or other relevant document. We understand that if any incorrect or misleading information results in a loss to the Fund, the Fund is entitled to recover the amount of such loss from us or by withholding from our future benefits. Employed Spouses Only: I hereby authorize my employer or other entities to release information regarding my employer's health insurance plan and my eligibility status for coverage under that plan to the Fund.

Participant Signature: _____Date: _____

Spouse Signature: _____Date: _____

TO UPLOAD FORM ONLINE

SCAN ME!

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