

# Plumbers Local Union No.1 WELFARE FUND

50-02 5<sup>th</sup> Street, Long Island City, New York 11101

Tel. (718) 223-4313 / (718) 835-2700

www.ualocal1funds.org

Date Received

Date Complete WF-9/24

FOR OFFICE USE ONLY

## Attestation Form for Retiree Coverage - SPOUSE

Please return the signed and completed form by **December 1, 2024** to the Fund Office in the enclosed envelope.

### (A) Member Information

Use a ballpoint pen to complete form

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(1) Social Security Number		(2) Last		(3) First		(4) Intl			
(5) Street			(6) City			(7) State		(8) Zip	
<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(9) Date of Birth		(10) Phone Number							
(11) E-mail Address									

### (B) Complete the below Attestations – please print clearly in black or blue ink only

#### Retroactive Disability Award:

- I attest that **my spouse has not** received a Social Security Disability Award.
- I attest that **my spouse has** received a Social Security Disability Award and I will notify the Fund Office immediately to discuss coverage options.
- I attest that **my spouse has** received a Social Security Disability Award and I previously notified the Fund Office as required.

#### Medicare Eligibility (for retirees under age 65):

- I attest that **my spouse** is under age 65 and is **not** eligible for Medicare.
- I attest that **my spouse** is under age 65 and is eligible for Medicare and I will notify the Fund Office immediately to discuss coverage options.
- I attest that **my spouse** is under age 65 and is eligible for Medicare and I have previously notified the Fund Office as required.

#### Notification of Future Changes:

- I understand that should **my spouse** receive a Social Security Disability Award or become Medicare-eligible in the future, I will notify the Fund Office immediately to discuss coverage options

### (C) Member Confirmation Statement

#### Signature and Acknowledgement: Please sign in blue or black ink only – *Electronic Signatures are NOT VALID*

I hereby confirm that all information provided in this attestation is true and accurate to the best of my knowledge. I understand that my failure to immediately notify the Fund Office of any changes in my status or my failure to comply with the terms outlined in the Plan may result in the termination of my retiree coverage.

DATE   -   -      
M M D D Y Y Y Y

(ORIGINAL SIGNATURE OF APPLICANT) – Wet Ink Signatures ONLY!

Retain a copy of this form for your records. Return the original to the Fund Office.

With possible delays by the US Postal Services, all documents should be sent by e-mail or text to info@nypl1f.org or by fax to 718-641-8155. Any questions should also be submitted by email or fax.

For questions: Please e-mail or text to info@nypl1f.org or by fax to 718-641-8155. You can also call the Fund Office Welfare Department at (718) 223-4313 or visit our web site at www.ualocal1funds.org.