Plumbers Local Union No.1 WELFARE FUND

50-02 5th Street, Long Island City, New York 11101 Tel. (718) 223-4313 / (718) 835-2700 www.ualocal1funds.org

Date Received Date Complete WF-10/24
FOR OFFICE USE ONLY

Attestation Form for Retiree Coverage
SPOUSE

Please return the signed and completed form by **December 1, 2025**
to the Fund Office in the enclosed envelope.

I Member Information

Use a ballpoint pen to complete form

[redacted] - [redacted] - [ ][ ][ ][ ]
(1) Social Security Number

(2) Last _____ (3) First _____ (4)Int

(5) Street _____ (6) City _____ (7) State _____ (8) Zip

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
(9) Date of Birth

[ ][ ][ ] - [ ][ ][ ] - [ ][ ][ ][ ]
(10) Phone Number

(11) E-mail Address _____

II Complete the below Attestations – please print clearly in black or blue ink only

A → SELECT ONE:

☐ **My spouse** is under age 65 ☐ **My spouse** is age 65 or older

B → MY SPOUSE IS RECEIVING SOCIAL SECURITY DISABILITY

☐ YES ☐ NO If **YES** is selected complete ***B1***. and ***B2***.

B1. *Have you provided your* ***spouse's*** *Social Security Award letter to the Fund office?*

☐ YES ☐ ***NO****, and I understand that I am required to submit a copy of* ***my spouse's*** *social security award letter along with this completed attestation form.*

B2. *Date of Social Security Disability Award* [ ][ ] - [ ][ ] - [ ][ ][ ][ ]

C → **MY SPOUSE** is ELIGIBILE FOR MEDICARE

☐ YES ☐ NO If **YES** is selected complete ***C1***. and ***C2***.

C1. *I have previously notified the Fund office of* ***my spouse's*** *Medicare status:*

☐ YES ☐ ***NO****, and I understand that I am required to submit a copy of* ***my spouse's*** *Medicare card to the Fund office along with this completed attestation form, and I will contact the Fund office immediately to discuss their coverage options.*

C2. **Medicare Start Date:** [ ][ ] - [ ][ ] - [ ][ ][ ][ ]

D → ***If you answered NO to sections B & C:***

☐ **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 our coverage options**

III 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 [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
(ORIGINAL SIGNATURE OF APPLICANT) – Wet Ink Signatures ONLY! M M D D Y Y Y Y

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.