



Spousal Affidavit

As the legal spouse of a Teamsters Security Fund for Southern Nevada – Local 14 (Trust Fund) member, in order to be covered under the medical plan starting January 1, 2026, you must sign and return this Spousal Affidavit to Zenith American Solutions at the address shown below.

Please check the appropriate box below.

I certify that I am:

- ☐ Not employed or retired.
- ☐ Not employed but enrolled in Medicare or Tricare as secondary coverage.
- ☐ Employed, but my employer does not offer group health plan coverage or part-time employee (additional documentation may be requested by the Fund Office).
- ☐ Employed and enrolled in my group health plan coverage effective January 1, 2026. ***If you check this box, please provide the information requested on the back of this form.***
- ☐ Employed and not enrolled in my employer's group health plan coverage as of January 1, 2026, and I DO NOT want to elect the monthly \$300 spousal self-pay. *Please note: Spouse will lose medical coverage with the Teamsters Health Plan effective January 1, 2026.*
- ☐ Employed and not enrolled in my employer's group health plan coverage as of January 1, 2026, and would like to elect the monthly \$300 spousal self-pay as of January 1, 2026. *Please note: If you elect this option, Zenith will mail you more information at a later date as to how you can make your monthly payment.*

I also certify under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct. I understand that providing false information or concealing important facts can be considered a violation of the law and punishable by a fine, imprisonment, or both and may result in the Plan's recovery of any benefits improperly paid.

Executed:

Spouse Name (Please print): _____

Spouse Signature: _____ Date _____

Member Name (Please print): _____

Member Signature: _____ Date _____

If you have any questions about spousal eligibility status, contact Zenith American Solutions before signing this document.

Please note:

- *The Plan reserves the right to request at any time documentation that substantiates the eligibility of an enrolled spouse.*
- *The Plan has the right to request reimbursement of any premiums and claims paid for ineligible*
- *Failure to complete this Spousal Affidavit fully and truthfully will make the spouse ineligible for Trust Fund health plan coverage during 2026.*

Complete if You Have Health Plan Coverage through Your Employer

If you are enrolled in group health plan coverage through your employer, effective January 1, 2026, please provide the following information:

Employer Name: _____

Insurance Company: _____

Group Number: _____

Effective Date: _____

Revised 09.15.2025