AMERICAN MARITIME OFFICERS (AMO) PLANS

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For AMO Official Use Only
Received Date: ________
Received By: __________

AFFIDAVIT OF PENSIONER'S MEDICAL BENEFITS EARNINGS LIMITATION AND COORDINATION OF BENEFITS

To be completed by both the Pensioner and Dependent Spouse. In order for this form to be accepted, you must answer every question.
This does not apply if you are 65 or older.

PENSIONER INFORMATION

1. Pensioner's Name:	SSN: XXX-XX-	DOB:
Street Address:		
City:	State:	ZIP Code:
Home Telephone No.:	Cell Phone No.:	
Email Address:		
2. Are you employed? ☐ Yes ☐ No	If yes, name of employer:	
Address of Employer:		
City:	State:	ZIP Code:
Employer Phone No.:	Effective Date of Employment:	
3. Are you covered by other health insurance? ☐ Yes ☐ No	If yes, effective date:	
Name of Carrier:	Carrier Telephone Number:	
4. What type of insurance is offered?	☐ Medical ☐ Prescription Drug ☐ Optical ☐ Dental	
5. Are you considered disabled by the Social Security Administration? ☐ Yes ☐ No	If yes, effective date:	
6. Are you eligible to participate in Medicare, Medicaid, or any other national, state, or governmental health insurance plan?	☐ Yes ☐ No	

EARNINGS RESTRICTIONS

Deep Sea, Great Lakes, and Inland Waters:
Calendar year earnings from gainful employment cannot exceed $28,320.00, which is equal to two times the amount permitted by Social Security.

If you are employed, will your earnings exceed the amount described above for 2010? ☐ Yes ☐ No

YOU ARE REQUIRED TO NOTIFY THE PLAN OFFICE IMMEDIATELY IF ANY CHANGE IN EMPLOYMENT AND/OR STATUS OCCURS. FAILURE TO DO SO MAY RESULT IN LOSS OF ELIGIBILITY FOR MEDICAL BENEFITS AND MAY REQUIRE REIMBURSEMENT OF ANY BENEFITS PAID FOR MEDICAL SERVICES ON PENSIONER AND/OR PENSIONER'S ELIGIBLE DEPENDENT'S BEHALF.

DEPENDENT INFORMATION

Dependent's Name	Social Security Number	Check Relationship to Participant				Date of Birth			Is dependent covered under another health plan?	
		Spouse	Natural Child	Step Child	Legal Guardianship/ Custody	Month	Day	Year	Yes	No

ELIGIBILITY

Eligibility requirements for a Pensioner and/ or Pensioner's eligible dependent:

- Pensioner and/ or Pensioner's eligible dependent must have earnings less than the amount described above under "Earnings Restrictions."
- In the event that Pensioner's eligible dependent's earnings exceed the amount permitted and medical benefits are paid during the calendar year in which the earnings exceed the annual limitations, then reimbursement shall be made to the Plan by the Pensioner.

Eligibility for a Dependent Spouse:

- The dependent spouse of a Pensioner who is eligible for medical benefits provided that any benefit payable with respect to such spouse shall cease upon the date of divorce or legal separation from the Pensioner.
- If the dependent spouse is employed full time, the Rules and Regulations of the AMO Medical Plan require that the Plan consider group medical coverage offered through a dependent spouse's full time employment first and the AMO Medical Plan will be secondary. For the purposes of determining full time employment status, 30 hours or more per week will be considered full time.
- If group medical coverage is rejected or waived by a dependent spouse, the AMO Medical Plan will only pay claims at 20% of the otherwise eligible benefit.

DEPENDENT SPOUSE INFORMATION

1. Dependent Spouse's Name:		SSN: XXX-XX-	DOB:
Street Address:			
City:		State:	ZIP Code:
2. Is the dependent spouse employed?	☐ Yes ☐No	☐ Part Time ☐ Full Time (30 hours or more per week.)	
If yes, name of employer:		Employer Phone Number:	
Address of Employer:			
City:		State:	ZIP Code:
3. Is dependent spouse eligible for Group Coverage through employment, or any other source?			☐ Yes ☐No
If yes, Carrier Name:		Policy Number:	
Carrier's Telephone Number:		Effective Date of Coverage:	
4. What type of Insurance is offered?	☐ Medical ☐Prescription Drug ☐Optical ☐Dental		
5. Have any of these been rejected or waived?	☐ Yes ☐No	If yes, date of rejection:	Medical ____________________ Prescription ____________________ Optical ____________________ Dental ____________________
6. If you are employed, will your earnings exceed the American Maritime Officers Medical Plan's Earnings Restrictions for 2010?			☐ Yes ☐No
7. Is dependent spouse eligible to participate in Medicare, Medicaid, or any other national, state, or governmental health insurance plan?			☐ Yes ☐No

DEPENDENT CHILDREN INFORMATION

1. Are there any legal documents assigning responsibility to provide medical coverage for any dependent children, stepchildren, or children under legal guardianship custody? If yes, provide the documents if you have not already done so.		☐ Yes ☐No
If yes, insured's name:	Name of Carrier:	
Carrier's Phone Number:	Effective Date of Coverage:	
Type of coverage:	☐ Medical ☐Prescription Drug ☐Optical ☐Dental	

2. If yes, insured's name:	Name of Carrier:
Carrier's Phone Number:	Effective Date of Coverage:
Type of coverage:	☐ Medical ☐Prescription Drug ☐Optical ☐Dental

CERTIFICATION OF INFORMATION

I understand that the American Maritime Officers Medical Plan does not provide health coverage to any Pensioner or Pensioner's dependent who has earnings from gainful employment that are in excess of the amount permitted under the Rules and Regulations of the American Maritime Officers Medical Plan. I will notify the Plan of any changes that occur which may change the status of my pensioner's coverage. I hereby certify that the information contained herein is true. I further understand that if I make false statements to American Maritime Officers Medical Plan, I may jeopardize my Medical Plan benefits and coverage and will be required to return benefits paid for medical services. I understand that the accuracy of the information contained herein as well as my compliance with the requirement to notify the Plan office of any changes that occur which may affect the status of my pensioner's coverage may be audited at any time by the AMO Plans internal auditor. In the event of such an audit, I may be required to provide information such as my or my eligible dependent's pay stubs, federal tax return or IRS Form W2. I understand that my failure to provide the requested information may result in the loss of eligibility for medical benefits and/ or the reimbursement for benefits that have been paid.

Participant's Signature	Date:

NOTARY PUBLIC

STATE OF ______________________)
COUNTY OF ______________________)

The foregoing instrument was acknowledged this _______ day of _______________, 20____, by ______________________________ (print name of participant), who personally appeared before me and acknowledged that he/she signed the instrument voluntarily for the purpose expressed in it.

______________________________ Signature of Notary Public ______________________________ Print, Type, or Stamp Commissioned Name of Notary Public ______________________________ Date Commission Expires	NOTARY SEAL	☐ Personally Known ☐ Produced Identification Type of Identification: ________________________