Cleveland-Cliffs Steel LLC
Spousal Coverage Status Inquiry

Active Employees and Retirees:

- **Non-Medicare Eligible Spouses working 32 or more hours per week and Non-Medicare Eligible Spouses who are retired and offered retiree coverage must enroll for all available coverage offered by their employer or former employer.**
- **If your spouse fails to enroll in available coverage, his/her coverage under the Cleveland-Cliffs Steel LLC Plan will be interrupted.**

POLICY HIGHLIGHTS:

- For a full description of your plan, refer to your appropriate Cleveland-Cliffs Steel LLC Summary Plan Description.
- Spousal and primary child premiums paid for coverage under the spouse's plan will be reimbursed.
- **A spouse is not required to enroll dependent children under their healthcare coverage**; however, a spouse who elects to enroll dependent children in their Employer sponsored plan will receive reimbursement for such dependent child/ren's premiums when the children are covered as primary under that Plan.

FORM INSTRUCTIONS:

- Complete all applicable questions.
- Employee/Retiree must sign and date form. By signing below, you are attesting that the information contained within this form is correct to the best of your knowledge.
- This form is the only method of updating your Spouse's coverage status.

EMPLOYEE/RETIREE: Please complete Side 1 and Side 2 (if necessary) of this form, date this form and indicate whether your spouse is employed.

Cleveland-Cliffs Steel LLC Employee/Retiree Name: _____ **Payroll #:** _____
(Active Only)

Employee/Retiree Date of Birth: _____ **and Last 4 Digits of SSN:** _____

Telephone #: **(** _____ **)** _____

Spouse Name: _____ **Spouse Date of Birth:** _____

PLEASE ANSWER THE QUESTIONS BELOW OR THIS FORM WILL BE RETURNED TO YOU FOR COMPLETION:

1. **Is your Non-Medicare eligible Spouse employed and working 32 hours or more a week:** **No** _____ **Yes** _____
2. **Is your Non-Medicare eligible Spouse retired and offered Retiree health insurance:** **No** _____ **Yes** _____

If no for both questions, sign and return this form to UMR. If yes for either question, complete this form on Side 2 then sign and return this form to UMR.

****PLEASE NOTE YOU MUST COMPLETE A NEW FORM IF YOUR SPOUSE'S COVERAGE STATUS CHANGES. If change is requested due to loss of coverage, you must provide a termination of coverage letter that contains your healthcare plan termination date and reason for coverage termination.**
TERMINATION DATE: _____ **REASON:** _____

Employee/Retiree Signature: _____ **Date:** _____

UMR
230 LEXINGTON GREEN CIRCLE, SUITE 400
LEXINGTON, KY 40503

OR

Fax the form to 859-226-1191 and retain the fax confirmation sheet for your records

OR

Scan and E-Mail the form to CliffsSpousalReimbursement@umr.com

FOR ANY QUESTIONS YOU MAY HAVE, PLEASE CALL UMR at 888-999-7741.

COMPLETE THE INFORMATION REQUESTED BELOW AND RETURN TO:

UMR
230 LEXINGTON GREEN
CIRCLE, SUITE 400
LEXINGTON, KY 40503

Employee/Retiree Name: _____ **Last 4 digits of SSN:** _____

Or fax the completed form to 859-226-1191 and retain the fax confirmation sheet for your records, or scan and E-mail to CliffsSpousalReimbursement@umr.com

TO BE COMPLETED BY EMPLOYEE/RETIREE (for spouse's other employer sponsored or retiree health insurance coverage):

1) Is your spouse offered their own employer sponsored or retiree health care plan coverage?

Yes_____ No_____ If "yes", effective date:_____

If yes, please check all coverages applicable: Medical_____ Dental_____ Vision_____ Rx_____ HMO_____

If not offered, indicate why:_____

_____

2) Is your spouse enrolled in their own employer sponsored or retiree health care plan coverage?

Yes_____ No_____ If "yes", effective date:_____

If yes, please check all coverages applicable: Medical_____ Dental_____ Vision_____ Rx_____ HMO_____

If not enrolled, indicate why:_____

_____

3) Does the health care plan offer child(ren) coverage? Yes_____ No_____ Are child(ren) enrolled for coverage? (circle answer)

Yes, primary Yes, secondary No

If so, what is the effective date of child(ren) coverage?_____

Order of benefit determination for child(ren): Birthday rule_____ Gender_____ Other _____

Name and Address of Spouse's Employer/Former Employer:

_____

_____

_____

Phone Number_____

Name and Address of Spouse's Plan/Administrator Carrier:

_____

_____

_____

Phone Number_____

FOR ANY QUESTIONS YOU MAY HAVE, PLEASE CALL UMR at 888-999-7741