ArcelorMittal USA

Spousal Premium Reimbursement Program 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 after open enrollment, his/her coverage under the ArcelorMittal USA Plan will be interrupted.**
- **Spouse coverage interruptions will also occur if form is not returned within 60 days from the end of the open enrollment period (November 4, 2016).**

POLICY HIGHLIGHTS:

- For a full description of your plan, refer to your appropriate ArcelorMittal USA Summary Plan Description.
- Any 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 and spouse 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 the front portion of this form, have your spouse sign and date this form and indicate whether he/she is employed.

ArcelorMittal USA Employee/Retiree Name:_____ **Payroll #:**_____
(Active Only)

Employee/Retiree Date of Birth or Insurance Card #:_____

Telephone #: (_____)_____

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

Is your Spouse Employed: Yes **No** **Spouse's Employer:**_____

Is your spouse employed 32 or more hours per week or is your Non-Medicare eligible Spouse retired and offered Retiree health insurance?

Yes _____ **If yes, complete the form on Side 2 and return to UMR.**

No _____ **If no, you and your spouse must sign and return the form on this page (Side 1) to:**

UMR
333 West Vine St, Suite 500
Lexington, KY 40507

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 AMSpousalReimbursement@umr.com

Employee/Retiree Signature: **Spouse Signature:** **Date:**

I authorize my employer to verify only the information on the reverse side of this form. No HIPAA protected information will be sought by the Company.

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

COMPLETE THE INFORMATION REQUESTED BELOW AND RETURN TO: UMR
333 West Vine St, Suite 500
Lexington, KY 40507

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

TO BE COMPLETED BY EMPLOYEE/RETIREE:

1) Is your spouse eligible or will he/she become eligible for health care plan coverage?

Yes_____ No_____ If "yes", eligibility date:_____

What Coverage is Available: Medical_____ Dental_____ Vision_____ Rx_____ HMO_____

2) If not eligible, indicate why:_____

3) Is your spouse currently covered by an employer-sponsored health care plan?

Yes_____ No_____ If "yes", effective date:_____

Check coverage enrolled: Medical_____ Dental_____ Vision_____ Rx_____ HMO_____

4) 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, effective date?_____

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

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

_____

_____

_____

Phone Number_____

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

_____

_____

_____

Phone Number_____

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