

TEACHERS' RETIREMENT SYSTEM OF KENTUCKY

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SERVING KENTUCKY TEACHERS SINCE 1940

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MEMORANDUM

TO: KTRS Retirees
FROM: KTRS Insurance Department
RE: Dropping Dependents

Outside of open enrollment, retirees may be allowed to drop a spouse and/or dependents from their plan ***IF a qualifying event (QE) has occurred and the required application/form is signed within 35 days.*** Please see the attached QE Chart.

If a qualifying event has occurred, you should complete the attached “Retiree Health Insurance Add/Drop Form” to make the appropriate change and return it ***with the required documentation*** (see QE Chart). Be mindful of the date you sign to avoid double coverage or a lapse of coverage, but ***no later than 35 days*** from the qualifying event.

If documentation is required and not provided, your application cannot be processed.

NOTE: If your qualifying event allows you to change your Option (LivingWell CDHP, LivingWell PPO, Standard PPO, or Standard CDHP), and you desire to do so, you must download and complete an ***application*** instead of an Add Form.

If you have any questions, please contact our office

QUALIFYING EVENT (QE) CHART WITH DOCUMENTATION REQUIREMENTS TO DROP/TERMINATE						Rev 6/2014
Event	Allowed Changes	Event Date	Signature Deadline	Effective Date	FORM REQUIRED	DOCUMENTS REQUIRED
Change in Legal Married Status						
Marriage	<ul style="list-style-type: none"> - Waiving coverage or Dropping Dependent(s) if Retiree gains coverage under Spouse's plan - Make Plan Option change if dropping Dependent(s)¹⁰ 	Date other group Health Insurance coverage is gained under Spouse's plan	35 calendar days from the Event Date	End of the month of signature date	Enrollment Application (to waive) OR Add/Drop Form	1 or 2 (on pg 2)
Divorce, Legal Separation or Annulment	<ul style="list-style-type: none"> - Drop Spouse - Drop Dependent(s) if gaining coverage under Spouse's plan - Drop Dependent(s) who cease to meet eligibility requirements (children of former Spouse are no longer eligible) - Change Plan Option¹⁰ 	Date the divorce decree, annulment or legal separation is entered by the court	35 calendar days from the Event Date (former spouse will be dropped even if deadline is missed)	End of the month in which divorce decree, legal separation, or annulment occurred	Add/Drop Form	3, 4 or 5 (on pg 2)
Spouse's Death	<ul style="list-style-type: none"> - Dropping deceased spouse from the plan - Changing Plan Option¹⁰ 	Date of death	35 calendar days from the Event Date	End of the month of the Spouse's death (the new plan, if applicable, will be effective the first day of the following month, regardless of whether the 35 day deadline is met)	Add/Drop Form	None
Change in Number of Dependents						
Dependent's Death	<ul style="list-style-type: none"> - Dropping deceased dependent from the plan - Changing Plan Option¹⁰ 	Date of death	35 calendar days from the Event Date	End of the month of the Dependent's death	Add/Drop Form	None
Judgment, Decree or Administrative Order relating to health coverage for child	<ul style="list-style-type: none"> - Drop child if order stipulates that coverage is to be provided by the other parent 	Date order is signed by the judge	35 calendar days from the Event Date	End of the month in which the child ceases to meet plan eligibility	Add/Drop Form	6 (on pg 2)
Change in Spouse or Dependent Employment Status						
Spouse or Dependent <u>gains</u> other employer-sponsored health coverage	<ul style="list-style-type: none"> - Dropping Retiree, Spouse, and/or Dependent(s) who become covered under Spouse's or Dependent's health plan - Changing Plan Option when dropping Spouse or Dependent(s)¹⁰ 	Date other coverage begins	35 calendar days from the Event Date	End of the month of signature date *This may be signed before the Event Date	Enrollment Application (to waive) OR Add/Drop Form	1 or 2 (on pg 2)
Change in Coverage Under Employer Plan						
Retiree or Spouse has different Open Enrollment Period	<ul style="list-style-type: none"> - Dropping Retiree, Spouse or Dependent(s) if Retiree or Spouse were enrolled during Open Enrollment period 	Last day of the other group's Open Enrollment Period	35 calendar days from the Event Date	Same as the Effective Date of the other group's election	Enrollment Application (to waive) OR Add/Drop Form	7 (on pg 2)

Change in Coverage under Employer Plan						
Retiree, Spouse or Dependent becomes entitled to Medicare (Parts A, B, or D)	- Dropping Retiree, Spouse and/or Dependent(s), if person becomes eligible and enrolled in Medicare - Changing Plan Option if dropping Spouse or Dependent(s) ¹⁰	Date Medicare becomes effective	35 calendar days from Event Date	End of the month of signature date	Enrollment Application OR Add/Drop Form	8 (below)
Retiree, Spouse or Dependent becomes entitled to Medicaid (gaining KCHIP is not a valid QE)	- Dropping Retiree, Spouse and/or Dependent(s), if person becomes eligible and enrolled in Medicaid - Changing Plan Option if dropping Spouse or Dependent(s) ¹⁰	Date Medicaid becomes effective	60 calendar days from Event Date	End of the month of signature date	Enrollment Application (to waive) OR Add/Drop Form	9 (below)
Incarceration	- Dropping Spouse or Dependent who becomes incarcerated	Date incarceration begins	35 calendar days from the Event Date	End of the month of signature date	Add/Drop Form	None

REQUIRED DOCUMENTATION

1. Letter from employer, on employer's letterhead, identifying:
 - a. Coverage effective date
 - b. Name(s) of person(s) covered by the policy
2. A copy of the new Health Insurance ID card(s) for each covered person, stating the coverage effective date (NOTE: Card issue date is **not** the same as the effective date)
3. Divorce decree signed by judge and date stamped "filed" or "entered"
4. Legal separation papers signed by judge and date stamped "filed" or "entered"
5. Annulment papers signed by judge and date stamped "filed" or "entered"
6. If dropping child on National Medical Support Notice (NMSN) you must have a NMSN rescinding the previous NMSN
7. Letter from employer on employer's letterhead, identifying:
 - a. Open Enrollment period and deadline
 - b. Effective Date of plan
 - c. Person(s) being added to the policy
8. Copy of Medicare card (showing effective date) or Initial eligibility letter from Medicare Office
9. Initial eligibility letter from Medicaid Office or Medicaid Eligibility/Termination Form signed by the Division of Medicaid Services
10. QE permits change in Plan Option (LivingWell CDHP, LivingWell PPO, Standard PPO, or Standard CDHP). Retiree must complete an application instead of Add/Drop Form.

NOTES:

- Military Insurance Coverage is considered "Another Employer Plan," however, Veteran's Administration (VA) benefits are **NOT** considered "Another Employer Plan."
- E-mails, online print-outs, or hand-written letters/forms will not be accepted as Qualifying Event documentation
- All Qualifying Event Forms should be signed within 35 days of the Qualifying Event (unless otherwise stated on the QE chart)



2016 KEHP RETIREE HEALTH INSURANCE ADD/DROP FORM

Section 1: To Be Completed by Insurance Coordinator/HR Generalist					
Retiree's SSN		Retiree Personnel Number		Home County Code	
Company Name	KTRS	Company Number	85000		
Date of Hire:	/ /	Coverage Effective Date		Org. Unit Number	10006418
Reason for Submission:	<input type="checkbox"/> Qualifying Event		<input type="checkbox"/> Other		
Section 2: Demographic Information					
Name (Last, First, MI)			Date of Birth		
Street Address		Home Phone Number		Cell Phone Number	
City, State, ZIP			Home Email Address		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Within the past 6 months, have you, or a spouse or dependent(s) age 18 and over, to be covered under your insurance plan, used tobacco regularly? Yes <input type="checkbox"/> No <input type="checkbox"/>		Are you Medicare Eligible due to Social Security Disability? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Married <input type="checkbox"/> Yes <input type="checkbox"/> No					

Section 3: Change Information					
Please select one QE Reason			Date of Event:		
Adding Dependents			Dropping Dependents		
Marriage	Copy of Marriage Certificate attached? Yes <input type="checkbox"/> No <input type="checkbox"/>		Divorce	Copy of Divorce Decree attached? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Birth/Adoption of Child	Copy of birth certificate or placement documents attached? Yes <input type="checkbox"/> No <input type="checkbox"/>		Death	No documentation required.	
Loss of Other Coverage	Letter from HR or Certificate of Prior Coverage attached? Yes <input type="checkbox"/> No <input type="checkbox"/>		Gaining Other Coverage	Letter from HR or Certificate of Prior Coverage Attached? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Loss of KCHIP/Medicaid	MET form attached? Yes <input type="checkbox"/> No <input type="checkbox"/>		Gaining Medicare/Medicaid	MET form attached? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Guardianship/Court Order	Copy of Court Order attached? Yes <input type="checkbox"/> No <input type="checkbox"/>		Other Permitted (explain):		

Section 4: Plan Election					
Benefit Option			Coverage Level		
LivingWell CDHP	I agree to the LivingWell promise <input type="checkbox"/>		Single (self only)		
LivingWell PPO	I agree to the LivingWell promise <input type="checkbox"/>		Parent Plus (self and child(ren))		
Standard PPO			Couple (self and spouse)		
Standard CDHP			Family (self, spouse, and child(ren))		
Waive Health Insurance (No HRA – not eligible)					

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Retiree's SSN									

Retiree's Name

Section 5: <i>Dependent Information</i>				
Spouse's Social Security Number	Name (Last, First, Middle Initial)	Birth Date <small>MONTH/DAY/YEAR</small>	Gender	Cross Reference Payment Option (LRP, JRP not eligible) <input type="checkbox"/> Yes <small>(Employee, Spouse & child(ren))</small>
		/ /		
Note: If Cross Reference Payment Option Complete This Information on Spouse:				
Spouse's Organizational Unit #:	<input type="checkbox"/> Dual Employee	<input type="checkbox"/> Hazardous Duty	Date of hire/retirement / /	Has Spouse used tobacco in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse's Company #:				
Child 1		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Ordered <input type="checkbox"/> Disabled
Child 2		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Ordered <input type="checkbox"/> Disabled
Child 3		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Natural <input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Step <input type="checkbox"/> Court Ordered <input type="checkbox"/> Disabled
Are any Dependents Medicare eligible due to Social Security Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, who?	

TOBACCO USE DECLARATION

The Commonwealth of Kentucky is committed to fostering and promoting wellness and health in the workforce. As a part of the KEHP wellness program, KEHP provides a monthly discount in premium contribution rates for non-tobacco users. You are eligible for the non-tobacco user premium contribution rates provided you certify that you or any other person to be covered under your plan has not regularly used tobacco within the past six months.

TOBACCO USE INFORMATION
Check the applicable box below:
Within the past six months, have you, or a spouse or dependent to be covered under your insurance plan, used tobacco regularly? Yes <input type="checkbox"/> No <input type="checkbox"/>
NOTE: Regularly means tobacco has been used four or more times per week on average excluding religious or ceremonial uses.
NOTE: "Tobacco" means all tobacco products including, but not limited to, cigarettes, pipes, chewing tobacco, snuff, dip, and any other tobacco products regardless of the frequency or method of use.
NOTE: "Dependent" means, for the purpose of the Tobacco Use Declaration, only those dependents who are 18 years of age or older.

By submitting this form, I certify the following:

1. I have truthfully checked the Yes or No box above that accurately reflects the use of tobacco products in the past six months regarding myself and persons to be covered as a spouse or dependent under my insurance plan.
2. I understand that the tobacco-user premium contribution rates will apply beginning January 1, 2016 if I answered "Yes" to the question above.
3. I understand that it is my responsibility to notify KEHP of any changes in my tobacco-use or that of my spouse or a dependent covered under my insurance plan, including notification to KEHP if all tobacco users become ineligible for coverage or are otherwise terminated during the plan year. Notification shall be made by completing a Tobacco Use Change Form.
4. I understand that if I or a spouse or dependent to be covered under my insurance plan currently use tobacco products and stop using tobacco products during the plan year, I will be eligible for the discount non-tobacco premium contribution rates on the first day of the month following the signature date on the Tobacco Use Change Form certifying that neither I nor my spouse/dependent(s) regularly used tobacco products during the six months prior to completion of the Tobacco Use Change Form.
5. I understand that if I answered "No" to the question above and either I or a spouse or dependent covered under my insurance plan become a regular tobacco user at any time, I must notify KEHP and my contribution rates will be adjusted to the tobacco-user premium contribution rates on the first day of the month following the signature date on the Tobacco Use Change Form.
6. I understand that this Tobacco Use Declaration is a part of my KEHP application for health insurance coverage. Any person who knowingly, and with the intent to defraud, files an application for insurance containing any materially false information, or who conceals, for the purpose of misleading, information concerning any fact material to the application, commits a fraudulent insurance act which is a crime.
7. I understand that if I fail to complete this Declaration truthfully, KEHP may adjust my contribution rates retroactively to apply the applicable higher tobacco-user premium contribution rates. Upon written notification, I will pay to KEHP the difference between the tobacco-user and the non-tobacco user premium contribution rates for the period for which I falsely certified eligibility for the non-tobacco user premium contribution rates.

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Retiree's SSN

Retiree's Name

8. The KEHP offers monthly discounted premium contribution rates to non-tobacco users as a part of its wellness program. Each KEHP member has at least one opportunity per plan year to qualify for the discount. KEHP is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Department of Employee Insurance at (888) 581-8834 or (502) 564-6534 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Review the Authorization and Certification information below.

Authorization and Certification for elections made by the planholder for health insurance coverage through the Kentucky Employees' Health Plan (KEHP or Plan), administered by the Department of Employee Insurance (DEI).

My signature on this form creates a legal and binding contract. By affixing my signature, I understand that:

- If I am electing a KEHP plan option or enrolling in an FSA during open enrollment, the plan and FSA will be effective January 1 of the following plan year. If I am a new employee or a newly eligible employee electing a KEHP plan option or enrolling in an FSA outside of open enrollment, the plan and/or FSA will be effective the first day of the second month after a new employee or newly eligible employee is eligible to enroll in the health plan or an FSA.
- I have read and understand the 2016 KEHP Benefits Selection Guide (BSG). Plan rules and limitations are contained in the KEHP Summary Plan Descriptions (SPD) or Medical Benefit Booklets (MBB) and the Summary of Benefits and Coverage (SBC).
- All KEHP benefits for my eligible dependents and me will be provided in accordance with the limitations in the SPDs, MBBs, BSG, and SBCs. I will abide by all terms and conditions governing participation in an FSA and as set forth in the SPD, and by all terms and conditions governing membership and receipt of services from the plan in which I have enrolled and as set forth in the SPD and MBB. In the event of a conflict between the terms of coverage stated in the SPDs, the MBBs, the BSG, and the SBCs, the terms of coverage stated in the SPDs and/or MBBs will govern.
- KEHP uses third parties, including Anthem, CVS Caremark, and WageWorks to provide certain administrative functions. KEHP may communicate with me directly or through these third parties about my coverage, my benefits, or health-related products or services provided by or included in KEHP's plan of benefits.
- If my spouse and I elect the cross-reference payment option, we are planholders with family coverage, and upon a loss of eligibility by either spouse, the remaining planholder will default to a parent plus coverage level. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/planholder.
- I certify that each enrolled dependent meets KEHP's dependent eligibility requirements as set forth in the SPD and/or the MBB. DEI may require supporting documentation to verify the eligibility of any dependent enrolled or requesting to be enrolled in the Plan.
- The elections indicated by this application may not be changed or cancelled during the plan year without a permitted Qualifying Event.
- Enrollment in an FSA is voluntary. I authorize my employer to deduct from my earnings the amount required to cover my employee contribution to the FSA I have selected, including any arrears I may owe. I authorize payment of my employee contributions to be made on a pre-tax basis.
- I authorize my employer to deduct from my earnings the amount required to cover my employee share of the premium contribution for the plan option I have selected, including any arrears I may owe. I authorize payment of my employee premium contributions to be made on a pre-tax basis unless I sign a Post-Tax Request Form.
- Any payment submitted to KEHP that I intend to be used to fund my FSA and any premium payment submitted to KEHP that I intend to be used to pay for my health insurance premium contributions may first be used to pay other priority debts that may be due and owing such as taxes and child support.
- If I choose a Dependent Care FSA, I am eligible to seek reimbursement, as authorized by 26 U.S.C. Sections 21 and 129, for dependent care expenses. The Dependent Care FSA may only reimburse eligible dependent care expenses that are incurred during the applicable coverage period.
- Any unused amount remaining in my Healthcare FSA at the end of the calendar year will be carried forward to the next calendar year, up to a maximum carry over amount of \$500.00.
- WageWorks will administer FSAs and HRAs for the 2016 plan year and will issue to me a WageWorks Healthcare Card for the payment of Healthcare FSA and HRA expenses. My WageWorks Healthcare Card will be suspended if the required claim verification is not sent to WageWorks within ninety (90) days after the card swipe. I agree to follow all rules and guidelines established by the Plan concerning the WageWorks Healthcare Card. The Plan reserves the right to deny access to the card, require repayment, deduct/withhold from my paycheck, and offset my Healthcare FSA or HRA if I fail to properly verify a claim.
- If I elect to waive KEHP health insurance coverage, with or without a Waiver Health Reimbursement Arrangement (HRA), I am doing so voluntarily. If your employer participates in the Waiver HRA program, there are two options available: the Waiver General Purpose HRA and the Waiver Dental/Vision Only HRA. I understand that I will be eligible for the Waiver General Purpose HRA only if I have other group health plan coverage.
- If I elect a Waiver General Purpose HRA, I declare that I am enrolled in another group health plan that provides minimum value. A "group health plan" refers to coverage provided by an employer, an employer organization, or a union. A "group health plan" does not include individual policies purchased through kynect or governmental plans such as TRICARE, Medicare, or Medicaid. A group health plan that provides "minimum value" means the plan pays at least 60% of the total allowed cost of covered benefits/services and participants or members in the plan are required to pay no more than 40% of the total allowed cost of covered benefits/services.
- If I elect a Waiver General Purpose HRA and I cease to be covered under another group health plan that provides minimum value, I will notify KEHP within 35 days of the date that the other group health plan coverage ceased. In this event, coverage under the Waiver General Purpose HRA will be terminated and I may elect a KEHP health insurance plan option or the Waiver Dental/Vision Only HRA. I am permitted to permanently opt out of and waive future reimbursements from the Waiver General Purpose HRA at least annually at open enrollment.
- Any funds remaining in a Waiver HRA after termination may be used to reimburse the employee for eligible expenses incurred prior to termination of the Waiver HRA. Upon termination of employment, the remaining amounts in a Waiver HRA are forfeited except that I may be reimbursed for any eligible medical expenses incurred prior to the last day of the last pay period worked, provided that I file a claim by March 31 following the close of the plan year in which the expense was incurred.

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Retiree's SSN

Retiree's Name

- KEHP provides plan options that, under the Affordable Care Act, constitute minimum essential coverage that is affordable and provides a minimum value. As such, by receiving an offer of coverage through my employer, I am not eligible for a health insurance premium tax credit if purchasing insurance through kynect. In addition, if I decline coverage for my spouse or dependent, my spouse or dependent will not be eligible for a health insurance premium tax credit if purchasing insurance through kynect.
- An HRA and/or Healthcare FSA may only reimburse me for medical expenses, as authorized by 26 U.S.C. Sections 105(b) and 213(d), that are incurred during the applicable coverage period. The Waiver Dental/Vision Only HRA may only reimburse me for eligible dental and vision expenses. Pursuant to federal law, the cost of over-the-counter medicines (other than insulin and those prescribed by a doctor) may not be reimbursed through my HRA or Healthcare FSA.
- I have a 90-day run-out period (until March 31) for reimbursement of eligible FSA and HRA expenses incurred during my period of coverage.
- Any unused amount remaining in my HRA at the end of the plan year may be carried forward to the next plan year provided I am eligible to elect an HRA. I must elect the same type of HRA in a subsequent plan year for the funds to carry over.
- The four KEHP plan options and the Waiver General Purpose HRA must pay primary to Medicare. The Waiver Dental/Vision Only HRA pays secondary to Medicare.
- The KEHP offers discounted premium contribution rates to non-tobacco users as a part of its wellness program. If either I or a spouse or dependent to be covered under my insurance plan have used tobacco regularly within the past six months, I will not qualify for the discounted employee premium contribution rates. Each KEHP member has at least one opportunity per plan year to qualify for the discount. KEHP is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees/retirees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Department of Employee Insurance at 888-581-8834 or 502-564-6534 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. KEHP does not collect or retain personal health or medical information through its wellness program; however, KEHP may receive aggregate information that does not identify any individual in order to design and offer health programs aimed at improving the health of KEHP members.
- If I have chosen one of the KEHP LivingWell plan options, I agree to fulfill the KEHP LivingWell Promise by completing (1) my online HumanaVitality Health Assessment; OR (2) a VitalityCheck (biometric screening). If I am choosing a LivingWell plan option during open enrollment, I will complete the Health Assessment OR a VitalityCheck (biometric screening) from January 1, 2016 through May 1, 2016. If I am a new employee and I choose a LivingWell plan option outside of open enrollment, I will complete the Health Assessment OR VitalityCheck (biometric screening) within 90 days of my coverage effective date.
- I have rights under HIPAA regarding the protection of my health information. KEHP will comply with the HIPAA Privacy and Security rules, and uses and disclosures of my protected health information will be in accordance with federal law. KEHP may use and disclose such information to business associates or other third parties only in accordance with KEHP's Notice of Privacy Practices available at kehp.ky.gov.
- Any person who knowingly, and with the intent to defraud, files an application for insurance containing any materially false information (including a forged signature or incorrect signature date), or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. I can be held responsible for any fraudulent act that I could have prevented while acting within my duties related to the KEHP, and it may be used to reduce or deny a claim or to terminate my coverage.
- I have fully read the materials provided to me. My signature on this application certifies that all information provided during this enrollment opportunity is correct to the best of my knowledge.
- Exceptions may apply to employees of certain employers participating in KEHP and to KTRS, KRS, LRP, and JRP retirees. Please refer to the participation rules of your employer or retirement system for further information.

PLEASE SUBMIT THIS FORM TO YOUR COMPANY IC/HRG

Employee Signature

Date

Spouse Signature – *REQUIRED* if electing the cross-reference payment option

Date

IC/HRG Signature

Date

IC/HRG Printed Name

IC/HRG Phone Number

Spouse's IC/HRG Signature – *REQUIRED* if electing the cross-reference payment option

Date

Spouse's IC/HRG Printed

Spouse's IC/HRG Phone Number