**Franklin Logistics, Inc.**
**153 Smith Transport Road**
**Roaring Spring, PA 16673**
**Phone: (800) 877-1173**
**Fax: (814) 224-6939**

# COVERAGE OF SPOUSE FORM

Please complete the following information:

1) Is your spouse employed? ( ) Yes ( ) No

( ) Full-Time or ( ) Part-Time

2) Who is your spouse employed by?

_____ _____
(name of company) (address)

_____ _____
(phone number) (fax number)

3) Is medical coverage available to your spouse through their employer?
( ) Yes ( ) No

**If answer is "yes" to question 3 it does not matter what type of coverage, the amount of hours your spouse works, or the price of the coverage, your spouse will <u>not</u> be eligible for Medical/Prescription coverage from Smith Transport, Inc./Franklin Logistics, Inc.**

I hereby certify that the above information is true and correct to the best of my knowledge. I further certify that I give Smith Transport, Inc./Franklin Logistics, Inc. permission to contact the above-mentioned Company and receive information about my health insurance information.

_____ _____
( **employee name** ) – please print ( **spouse's name** ) – please print

_____ _____
( employee signature ) ( spouse's signature )

_____ _____
( date ) ( date )

Revised: 1/6/2014