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 info	rmation):			
1) Is your spouse employed?	() Y	es		() No
(() Full	-Time	or	() Part-Time
2) Who is your spouse employed by	y?				
(name of company)					(address)
(phone number)		(fax number)			
3) Is medical coverage available to (If answer is "yes" to question 3 it o of hours your spouse works, or the eligible for Medical/Prescription co Logistics, Inc.) Yes does no e price o	ot matte	r wha	No at ty ge,	pe of coverage, the amount your spouse will <u>not</u> be
I hereby certify that the above info- knowledge. I further certify that I g permission to contact the above-m my health insurance information.	ive Smi	th Trans	sport,	Inc	./Franklin Logistics, Inc.
(employee name) – please print		(sp	ouse':	s na	me) – please print
(employee signature)	_		(spou	ıse's	s signature)
(date)	-			((date)

Revised: 3/1/12