2023 Spousal Verification Form

Employee Legal Name:		Spouse Legal Name:

SPOUSES: Please select and complete the section that applies to you.

SECTION I: I DO have group health coverage OTHER THAN through the City of Canton.

Insurance Company or Plan Name: _____

Insurance Address: _____

Insurance Company/Plan Phone Number: _____

Original Effective Date: _____ Policy/ID# _____

Employer Name & Address: _____

Coverage Includes:

____Medical & Prescription Drug…… ____ Employee Only ____ Family (Please list) _____

Is this Retiree Coverage: ____Yes ____ No Do you have Medicare Coverage: _____ Yes _____No

If Yes, please provide your Medicare Effective Date: _____

SECTION II: I DO NOT have coverage because . . .

____ I am not employed

If health coverage terminated within the last year, please indicate the date your coverage ended: _____

(If so, please submit a copy of your Certificate of Creditable Coverage)

____ I am Self-Employed - Name and Type of Business _____

SECTION III: I am employed, but do not have coverage in my employer's health plan because . . .

_____ I will be eligible for coverage after Open Enrollment or after a Waiting Period beginning: _____

_____ I am employed 30 hours or less per week.

_____ My employer does not offer health coverage.

_____Other. Please explain_____

_____

_____ My employer offers health coverage but my contribution toward the premium is greater than $200 per month for Single coverage. Please include a Summary of Benefits and proof of premium expense.

Employer Verification: Must be completed by Employer if Section III is completed

I hereby certify the person on this form is an employee of the Employer and the information supplied by the employee is accurate and complete to the best of my knowledge.

Employer Name _____

Employer Representative Signature_____ Date_____

Employer Representative (Please Print) _____

Position_____ Phone_____

EMPLOYEE/SPOUSE SIGNATURE AND AUTHORIZATION: BOTH MUST SIGN

We hereby declare under penalty of perjury that we are legally married and the information on this form is correct and complete to the best of our knowledge. We authorize the City of Canton Health Plan to verify the spouse's employment status as needed. If requested by the Plan, we agree to obtain and furnish a copy of any marriage certificate, divorce decree, or other relevant document. We understand that if any incorrect or misleading information results in a loss to the Plan, the Plan is entitled to recover the amount of such loss from us or by withholding from our future benefits. Employed Spouses Only: I hereby authorize my employer or other entities to release information regarding my employer's health insurance plan and my eligibility status for coverage under that plan.

Employee Signature _____Phone _____

Spouse Signature_____ Phone _____

Date_____