Spousal Employment Verification Form

The City of Columbus offers health care coverage to qualifying employees and their dependents. Some conditions may affect coverage for you and your dependents. The City of Columbus Health Plan has a Working Spouse Rule. If your spouse is employed and eligible for insurance through his/her employer, the spouse will not be eligible for this plan.

Please answer all questions and attach to your enrollment form. If you do not wish to cover your spouse on your plan, you do not need to complete this form.

Is your spouse employed?

- ◯ Yes If yes, please list the employer's name _____
- ◯ No

Does your spouse's employer offer medical insurance?

- ◯ Yes
- ◯ No

Is your spouse eligible for coverage under the employer's medical plan?

If your spouse is not eligible, a statement from your spouse's employer that verifies that coverage is not available is required.

- ◯ Yes Date your spouse becomes eligible under their employer's plan _____
- ◯ No

Is your spouse currently covered on the medical plan offered by the employer?

- ◯ Yes If yes, effective date of coverage _____
- ◯ No

Please provide the name, address and telephone number of your spouse's medical insurance carrier or plan.

I certify that the information furnished above is complete and accurate to the best of my knowledge. I understand that the City may request more information and I have a duty to provide that information, SIHO may at any time audit this information and independently verify this information and any inaccuracy may affect coverage for past or future claims. I understand that providing false information on City forms may affect my status as an employee at the City of Columbus. In addition, I understand that if there are any changes in the information, it is my responsibility to immediately report this to my employer/former employer at the time of the change (example: if my spouse becomes employed and is offered health insurance, I must immediately provide this information to the Benefits Coordinator at the City). I accept responsibility for any claims paid incorrectly because of the incomplete or inaccurate information provided on this form and I acknowledge my duty to accurately complete this form.

Signature Date

Print Name