BENTON COUNTY SPOUSE HEALTH PLAN VERIFICATION FORM

A. EMPLOYEE INFORMATION

Name: (Last, First, MI)

Address:

City, State, Zip:

B. ENROLLMENT STATUS

Section 1

1 ☐ ***My spouse is NOT on the Benton County Health Plan***

You are now complete with this form. Please sign section 1 and return to Human Resources.

2 ☐ ***My spouse is SELF-EMPLOYED AND on the Benton County Health Plan***

You are now complete with this form. Please sign section 1 and return to Human Resources.

3 ☐ ***My spouse is NOT EMPLOYED AND on the Benton County Health Plan***

You are now complete with this form. Please sign section 1 and return to Human Resources.

By signing below, I attest that all information provided is accurate and I fully understand the spousal fee waiver requirements. Failure to provide true and correct information, may result in termination of the employee's health coverage (as well as any covered dependents).

Employee Signature:_____ **Date:** _____

Section 2

4 ☐ ***My spouse is employed AND on the Benton County Health Plan***

Spouse Name: (Last, First, MI)

If your checked BOX "4" please read and sign below.

I certify that the spouse named above is my lawful spouse. **I understand that I will be required to provide a copy of my marriage certificate.** I certify that if I become divorced from the individual that I will notify the Human Resources Department within 30 days following the event date to remove the individual and any children that are no longer my legal dependents as a result of the divorce.

By signing below, I attest that all information provided is accurate and I fully understand the spousal fee waiver requirements. Failure to provide true and correct information, or failure to report a change in health coverage eligibility through his/her employer, may result in termination of the employee's health coverage (as well as any covered dependents).

I understand this form must be completed and submitted with any other required documentation (if applicable), in order to cover my spouse on the Benton County Health Plan.

Employee Signature:_____ **Date:** _____

Please provide form to your spouse's employer to complete. See Page 2

SPOUSE HEALTH PLAN EMPLOYER CERTIFICATION

Only to be completed if Section 2, on page 1, is selected.

A. SPOUSE INFORMATION

Name: (Last, First, MI)

(Spouse of Employee/Subscriber listed in Section II)

B. EMPLOYER'S CERTIFICATION - To be completed by EMPLOYER

Dear Employer,

Please complete this certification for your employee named in Section II above.

It has been indicated by our employee that you are the employer of their spouse. Because of our special provision, additional information is required to make a proper evaluation of the spouse's eligibility. Your assistance in completing the following is appreciated.

1. **Do you provide Group Health Coverage for your employees?**
   - ☐ Yes, (Continue to #2)
   - ☐ No, (Continue to Section C)
2. **Is the above-named employee eligible to enroll in this Health Coverage?**
   - ☐ Yes. (Continue to Section C)
   - ☐ No. Please indicate why:_____(Continue to Section C)
3. **Does your health coverage meet the Affordable Care Act requirements of being "affordable with minimum essential services"?**
   - ☐ Yes, (Continue to Section C)
   - ☐ No, (Continue to #4) Please attach a copy of the Health Insurance Marketplace Notification indicating coverage does not meet affordability and minimum essential services requirements.
4. **Does your plan recognize a spouse's Open Enrollment as a qualified life event?**
   - ☐ Yes
   - ☐ No, please provide us with your Plan Year Effective Date: _____

C.EMPLOYER REPRESENTATIVE SIGNATURE

I certify to the best of my knowledge that the information provided above is accurate. I further acknowledge that I am a Benefits Representative or a Human Resource Representative of the company stated below.

Employer Name: _____

(Employer Representative Signature)	(Employer's Title)
(Contact Phone Number)	(Date Signed)