

# SPOUSAL EMPLOYER VERIFICATION FORM

Ohio Healthcare Plan requires spouses of covered employees to join their employer's group health plan, for at least a single/individual coverage, where such eligibility to coverage exists. In order for your employee to be considered for medical coverage with Ohio Healthcare Plan this form must be completed and returned by the employee.

## To be completed by Member

Member Name:

Spouse's Name:

Spouse's Date of Birth:

## To be Completed by Spouse's Employer

Company Name

Company Address

Our Company's Health Plan year ends on: \_\_\_\_\_ (Example Dec 31, XXXX)

- |                          |  |  |
|--------------------------|--|--|
| <input type="checkbox"/> | My employee <b>is</b> eligible for medical coverage through our organization.  | <i>If checked, this employee must enroll in primary coverage through your employer-sponsored medical plan, for at least individual coverage.</i>         |
| <input type="checkbox"/> | My employee <b>is not</b> eligible for medical coverage through our organization.<br><b>Reason not eligible:</b> _____   | <i>If checked, this employee is <b>NOT</b> required to enroll in your employer-sponsored medical plan, as long as this situation applies.</i>            |
| <input type="checkbox"/> | My employee is eligible for our employer-sponsored medical plan and would have to pay <b>more than 50%</b> of the total premium rate for their individual/single rate. This would be more than 50% of your lowest cost plan. <b>*(see below)</b> | <i>If checked, this employee is <b>NOT</b> required to enroll in your employer-sponsored or retiree medical plan, as long as this situation applies.</i> |

Single Plan Premium \_\_\_\_\_ Employer Share \$ \_\_\_\_\_ Employee Share \$ \_\_\_\_\_

**NOTE:** Total Premium rate **shall not** include any incentives paid to waive coverage or to increase compensation.

## Employer Insurance Information –Complete this section only if the Employee is covered on the plan

Other Insurance Information	Medical Carrier	RX Carrier (if different from Medical)
Insurance Company Name		
Insurance Company Address		
Group Policy Number		
Type of Policy (PPO, HDHP/HSA, EPO or HMO)		
Effective Date		
Coverage Type	Employee Only <input type="checkbox"/> Family <input type="checkbox"/>	Employee Only <input type="checkbox"/> Family <input type="checkbox"/>

### Dependents Covered Under Above Policy

**NOTE:** Falsifying employment status is fraud and will result in financial penalty and/or loss of coverage for the spouse covered under OHP. Falsifying information may also be prosecuted to the fullest extent of the law.

The above responses are correct to the best of my knowledge.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Employer or Employer's Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
EXT.



Employee may upload this document on the enrollment site <https://ohp.benelogic.com>.  
You may also fax to 419-267-5262

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