SPOUSAL EMPLOYER VERIFICATION FORM

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

To be Completed by Member (This section MUST be completed)

Member Name:
Spouse's Name:
Spouse's Date of Birth:

To be Completed by Spouse's Employer

Company/Employer Name	
Company/Employer Address	
Company/Employer Phone Number	Employee's effective date of coverage:

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

☐	My employee **is** eligible for medical coverage through our organization.	*If checked, this employee must enroll in primary coverage through your employer-sponsored medical plan, for at least individual coverage.*
☐	My employee **is** eligible for a retiree health plan.	*If checked, this employee must enroll in primary coverage through your retiree medical plan, for at least individual coverage.*
☐	My employee **is** eligible for a stipend for health coverage. Stipend Amount: $_____	*If checked, this employee MUST enroll in primary coverage elsewhere and is only eligible for secondary coverage with SHP.*
☐	My employee **is not** eligible for medical coverage through our organization. **Reason not eligible:** _____	*If checked, this employee is NOT required to enroll in your employer-sponsored medical plan, as long as the situation applies.*
☐	My employee is in a probationary period and **will be** eligible for medical coverage through our organization on: **(Date Eligible):** _____	*If checked, this employee must enroll in primary coverage through your retiree medical plan, for at least individual coverage.*
☐	My employee **is** eligible for our employer-sponsored or retiree medical plan, but would have to pay **more than 50%** of the total premium rate for the individual/single rate. This would be **more than 50%** of your lowest cost plan. **Premium Shares must be filled in below:	*If checked, this employee is NOT required to enroll in your employer-sponsored or retiree medical plan, as long as the situation applies.*

LOWEST COST Single Premium Plan Employer Share $_____ Employee Share $ _____

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

Employer Insurance Information- Complete this section only if your Employee is covered on your plan.

Other Insurance Information	Medical Carrier	RX Carrier (if different from Medical)
Insurance Company Name		
Group Policy Number		
Type of Policy: (PPO, HDHP/HSA, EPO or HMO)		
Effective Date		
Coverage Type	Employee Only ☐ Family ☐	Employee Only ☐ Family ☐

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 SHP. 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://shp.benelogic.com or return to your Treasurer or Personnel Office.

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