2017 SPOUSAL MEDICAL INSURANCE VERIFICATION FORM – Open Enrollment

Employee Name: _____ Employee ID# or SS#: _____

Spouse's Name: _____ Spouse SS#: _____

Name and Address of Spouse's Employer (if employed and enrolling in WellSpan medical):

Name: _____ Address: _____

Please complete and return this form **by December 12** if you plan to cover your spouse in a WellSpan medical plan for **2017.** Check the statement that applies to your spouse and complete the Employee & Spouse Information section. Have Spouse's Employer complete Confirmation Section if applicable.

1. **_____My spouse is employed and eligible for medical coverage and the cost is less than shown below.** *(In order to stay on WellSpan's plans, your spouse must also enroll in his or her own employer provided plan.)*

2. **My spouse is employed and eligible for medical but:**

   _____ the cost of single coverage in the least expensive plan is over $200/month. Note: Opt-out credits are not considered part of the cost. *(Do not need to enroll in spouse's employer plan.)* **OR**

   _____ the cost is $200 or less but my spouse is required to pay 51% or more of the total cost of single coverage for the lowest costing plan. *(Do not need to enroll in spouse's employer plan.)*

3. **My spouse is:**
   _____ self-employed as main occupation and no medical coverage is available through another employer,
   _____not employed _____ employed but not eligible for medical coverage _____ employed by WellSpan.
   (Do not need to enroll in spouse's employer plan.)

If you checked #1 your spouse **is** required to elect single coverage in his or her employer sponsored plan if you elect to cover him or her in the WellSpan medical plan. **If you checked #2 or #3,** your spouse is **not** required to enroll in his or her own employer's plan in order to enroll in a WellSpan plan.

I certify that the statements made on this document are true, complete, and accurate to the best of my knowledge. I also agree to notify WellSpan in the event any of the facts or information provided on this form changes due to a change in my spouse's employment and/or medical insurance status.

_____ _____ _____

Employee's Signature Spouse's Signature Date

SPOUSE'S EMPLOYER CONFIRMATION (check all that apply):

_____Our Company does not offer medical coverage or the spouse listed above is not eligible for medical coverage at this time.

_____ Employee cost of single coverage for the lowest costing medical plan is more than **$200**/month or employees pay more than **50%** of the cost of single medical insurance for our lowest cost medical plan.

_____ This employee is enrolled in our medical coverage for 2017.

Contact person and telephone number of spouse's Employer (please print):

Name: _____ Telephone #: _____

Signature of Employer Contact Person: _____ date: _____

Return to: Benefits@WellSpan.org **Fax:** (717)-851-3100 rev. 5-2016