SOUTHERN STATE COMMUNITY COLLEGE

Spouse Health Benefits Verification Form

All spouses must complete a verification form for Spouse Coverage regardless of employment status, in order to obtain coverage under the College's insurance plan. Working spouses, who are eligible for health coverage through their employer, are required to enroll in their employer-sponsored health plan before enrolling in the College's health plan. The College will provide secondary coverage for spouses who are covered by their employer's plan.

Spouse: Please complete the section below that best applies to your situation.

Section I

☐ I have group health coverage other than Southern State Community College's plan (fill in coverage information below).

Insurance Company or Plan Name:_____

Insurance Company/Plan Phone Number:_____

Original Effective Date:_____ Policy/ID#:_____

Name of Employer:_____Employer's phone number:_____

Coverage Includes:
☐ Medical & Prescription Drug
☐ Vision
☐ Dental
Do you have Medicare coverage? ☐ No ☐ Yes If yes, provide Medicare Effective Date:_____

Section II

☐ I do not have or no longer have group health coverage other than Southern State Community College's plan.

Please select ONE box below to best describe why you do not have coverage.

☐ I am not or am no longer employed. Last day worked:_____

☐ I am self-employed. Name and Type of Business._____

☐ I am employed, but do not have coverage in my employer's health plan for the reason indicated below:

A. ☐ I will be eligible for coverage on:__ _____
B. ☐ I am an employee currently in a "waiting period." Coverage will begin on:_____
C. ☐ I am employed 30hrs or less a week.
D. ☐ My employer does not offer health coverage.
E. ☐ Other: Please Explain_____

Employer Verification: Must be completed by the employer.

Employer Name:_____

I hereby certify the person on this form is an employee of the Employer above and the information supplied by the employee is accurate and complete to the best of my knowledge.

Employer Representative Signature:_____ Date:_____

Employer Representative (Please Print)_____Position: _____ Phone:_____

** Please contact the SSCC Webmaster at webmaster@sscc.edu for suggested updates or changes to this form **