

SPOUSAL EMPLOYER VERIFICATION FORM

Northern Buckeye Health Plan requires spouses of covered employees to join their employer's group health plan, for at least individual coverage, where such eligibility to coverage exists. In order for your employee to be considered for medical coverage with Northern Buckeye 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 Name

Company Address

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

<input type="checkbox"/>	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.
<input type="checkbox"/>	My employee is eligible for a retiree health plan.	If checked, this employee must enroll in primary coverage through your employer-sponsored medical plan, for at least individual coverage.
<input type="checkbox"/>	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 NBHP.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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 employer-sponsored medical plan, for at least individual coverage.
<input type="checkbox"/>	My employee is eligible for our employer-sponsored or retiree medical plan and would have to pay more than 50% of the total premium rate for their 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 plan 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 Information (Complete only if your employee has coverage through your organization).

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 <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 NBHP. 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 HR Administrator Signature _____

Date _____

Phone Number _____

EXT. _____

Employee may upload this document on the enrollment site <https://nbhp.benelogic.com> or return to your Treasurer or Personnel Office.

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