WORKING SPOUSE COVERAGE VERIFICATION FORM

This form is used to verify whether a spouse has access to employer sponsored medical coverage and to determine eligibility for coverage under the Blessing Health System Health Plan.

Return by 12/15/26 to Human Resources or scan and e-mail to HRTotalRewards@blessinghealth.org

Employee Certification Section (to be completed by Blessing employee)

Blessing Employee Name: _____ Emp ID: _____

Spouse's Name: _____ Spouse's DOB: _____

Spouse's Employer: _____

I certify that the information provided on this form is true and complete to the best of my knowledge.
I understand that spouse eligibility for coverage under the Blessing Health System Employee Health Plan is determined according to plan eligibility rules.
I agree to notify Blessing Health System within 30 days if my spouse gains access to, loses access to, or experiences a change in eligibility for employer sponsored medical coverage.
I understand that providing false, incomplete or misleading information may result in retroactive termination of coverage, recovery of claims paid on behalf of an ineligible dependent and corrective or disciplinary action up to and including termination of employment:

Blessing Employee Signature: _____ Date: _____

Employer Certification Section (to be completed by Spouse's employer or HR representative)

Employer Representative Name: _____

Title: _____

Phone Number: _____ Email Address: _____

1. Is the above-named spouse currently employed by your organization? ____YES ____NO
2. Does your organization offer medical coverage to eligible employees? ____YES ____NO
3. Is the above-named spouse eligible for coverage under your organization's medical plan? ____YES ____NO

If #3 is YES, please indicate the date they become eligible for coverage: _____

If #3 is NO, please indicate a reason:

_____Employee is currently in a waiting period.

_____Employee's current status is not eligible for health insurance

_____Other: _____

I certify that the information provided on this form it true and accurate to the best of my knowledge.

Employer Representative Signature: _____ Date: _____