SPOUSAL EMPLOYER VERIFICATION FORM

Ohio Healthcare Plan requires spouses of covered employees to join their employer's group health plan, for at least single/individual coverage, where such eligibility to coverage exists. In order for your employee to be considered for medical coverage with Ohio Healthcare 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)

☐	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 stipend for health coverage. Stipend Amount: $_____	*If checked, this employee must enroll in primary coverage elsewhere and is only eligible for secondary coverage with OHP.*
☐	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 this 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 employer-sponsored medical plan, for at least individual coverage.*
☐	My employee i**s** eligible for our employer-sponsored 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 or retiree medical plan, as long as this situation applies.*

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

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

Employer Information (Complete this section 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 ☐ 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 OHP. Falsifying information may also be prosecuted to the fullest extent of the law.

The above responses are correct to the best of my knowledge.

OHIO Healthcare PLAN
Central Division of OHI

_____
Print Name

_____ _____
Employer or Employer's Representative Signature **Date** **Phone Number** **EXT.**

Employee may upload this document on the enrollment site https://ohp.benelogic.com
or you may fax to 419-267-5262.

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