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

Member Name:

Spouse's Name

Spouse's Date of Birth:

To be Completed by Spouse's Employer

Employer:

The Wapakoneta City Schools Health Benefit Plan requires that a determination be made concerning the eligibility of a spouse for coverage. The information you provide below will help Wapakoneta City Schools make this determination.

Wapakoneta City Schools has adopted a Spouse Eligibility Rule which requires an employed spouse of a Wapakoneta City School's employee to enroll in single coverage in the medical plan offered by or through contributions of their employer. If a spouse is eligible for coverage through his/her employer, he/she is <u>not</u> eligible to enroll in the Wapakoneta City Schools Health Insurance Plan. The spouse must enroll in his/her plan and is <u>not</u> eligible for secondary coverage through the Wapakoneta City Schools Health Insurance Plan.

If your plan is governed by Section 125 regulations, loss of coverage is generally recognized as a status change. HIPAA regulations require a special enrollment period for individuals who previously declined coverage for themselves and their dependents without having to wait until the plan's open enrollment period. A special enrollment period occurs if a person with other health insurance coverage loses that coverage.

Please complete the following applicable information on your employee:

Date Health Insurance coverage began __/__/____

We offer Health Insurance; however, this employee is not eligible to enroll because _____

_____

____ We do not offer health insurance.

Employer Name: _____

Print Name of Company Representative: _____

Signature of Company Representative: _____

Phone: _____ Date: _____

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.

Please return this form to Dana Webb. If you have questions, please call Dana at 419-739-2907.

NORTHERN BUCKEYE Health PLAN
NW Division of OHI

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