# Working Spouse Employer Verification Form

**Diocese of Cleveland**
**1404 East 9th Street, 8th Floor, Cleveland, OH 44114-1722**
**216-696-6525 x5040; hbo@dioceseofcleveland.org**
**Fax:216-621-9622**

## *Instructions:*

1. **Complete Participant Section**
2. **If spouse is employed, have your spouse sign the authorization and spouse's employer complete the Employer Section**
3. **Return original to Diocesan Employee Benefits Office**

***Participant Information (Please Print)***

**Employee Name:** _____

**Employer:** _____

**Spouse's Name:** _____

**Check if no Spouse** ☐

***If spouse is not employed, check here to certify and sign affidavit below:*** ☐

***I understand this form must be completed in order to cover my spouse on my Diocese of Cleveland Group Health Insurance plan. This form is used to determine a spouse's eligibility to receive primary health benefits on the Diocesan plan. If any of this information changes, I must complete a new form within 30 days of the change.***

***X*** _____ _____
***Diocese of Cleveland Participant Signature*** ***Date***

### *Spouse's Authorization to Release Information*

***I hereby authorize my employer to release information requested below in the course of my benefit verification. I also understand that if there is any change in this information, I must notify the Diocese of Cleveland within 30 days of the change.***

***X*** _____ _____
***Signature of Spouse of Diocese of Cleveland Participant*** ***Date***

### *Spouse's Employer Section*

***This Section Only Needs to be Completed if Spouse is Actively Employed***

***(To be completed by an authorized representative of the spouse's employer)***

**Employer Name and Address:**

_____

_____

_____

**1. Does your company offer medical benefits to employees? YES_____ NO_____**

**2. Is the above-named spouse eligible for benefits? YES_____ NO_____**

**If no, please explain:** _____

**3. Is the above-named spouse enrolled in your medical plan? YES _____ NO_____**

**If yes:**

_____ _____
**Name of Insurance Plan** **Effective Date of Coverage**

**4. Will the above-named spouse, if not currently eligible, be eligible to enroll in the medical plan in the future? YES_____ NO_____ If so when?** _____

_____ _____
**Employer Representative Name (Please Print)** **Phone Number**

_____
**Job Title**

***X***_____ _____
**Signature** **Date**