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**