

Working Spouse Employer Verification Form

Diocese of Cleveland
1404 East 9th Street, 8th Floor, Cleveland, OH 44114-1722
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Fax:216-621-9622

Instructions:

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

Participant Information (Please Print)

Employee Name: _____

Spouse's Name: _____

Employer: _____

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)

Spouse's 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 your medical plan in the future? YES _____ NO _____ If so, when? _____

Employer Representative Name (Please Print) Phone Number

Job Title

X _____
Representative's Signature Date