TEXAS ASSOCIATION *of* COUNTIES
HEALTH AND EMPLOYEE BENEFITS POOL

SPOUSE ELIGIBILITY VERIFICATION FORM

In order to enroll an eligible spouse in the _____ group health plan, this form must be filled out to verify other coverage.

I. Employee Information

SECTION A: Employee Information

Name: _____

Social Security Number: _____

II. Spouse Coverage Verification

A spouse must first be enrolled in any available employer-sponsored group health plan. This form must be completed if you are applying for spouse coverage. If your spouse is self-employed, the employer is his/her company. If your spouse is unemployed or retired, you do not need to complete SECTION B of this form, proceed to the Acknowledgement page; sign, date and return to your employer.

- Is your spouse employed? ☐Yes ☐No
- Is your spouse self-employed? ☐Yes ☐No
- Is your spouse retired? ☐Yes ☐No

SECTION A: Spouse Information

Name: _____

Social Security Number: _____

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SECTION B: Spouse Employment Information

Spouse Employer/Business Name: _____

Employer Address: _____

Work Phone Number: _____

Supervisor Name: _____

Date of Employee (Spouse) Hire or Business Start Date: _____

Does employer offer group health benefit coverage, either insured or self-insured?
☐ Yes ☐ No

Waiting Period for Employer Health Coverage (if any): _____

If the employer does not provide a group plan, is coverage for the employee provided through individual health insurance coverage? ☐ Yes ☐ No

If insured, either through a group policy or individual policies, provide the name and telephone number of insurance company: _____
_____

SPOUSE ELIGIBILITY VERIFICATION

Employee Acknowledgement

I hereby certify that I have read this document and the answers are true and correct. I further understand that a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as Texas Association of Counties Health and Employee Benefits Pool, for a person who is ineligible for such plan, is a violation of the anti-fraud provisions of the Health Insurance Portability and Accountability Act, 18 USC § 1035, to which civil and criminal penalties, including imprisonment, can apply.

Employee Signature: _____

Title/Dept: _____ Date: _____

PLEASE RETAIN A COPY OF THIS DOCUMENT FOR YOUR FILES
& RETURN ORIGINAL TO YOUR EMPLOYER