TEXAS ASSOCIATION of COUNTIES
HEALTH AND EMPLOYEE BENEFITS POOL

SPOUSE ELIGIBILITY VERIFICATION FORM

In order to enroll an eligible spouse in the Entity Name's 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: _____

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