2024 Spousal Medical Insurance Verification Form

Must be completed and return to HR within 31 days of New Hire start date or a qualified life event.

WellSpan Employee Name:	Employee ID or Last 4 Digits of SSN:
Spouse Name:	Last 4 Digits of SSN:

☐ My Spouse meets one of the criteria below and my understanding is they can be covered as PRIMARY on my WellSpan medical plan:

a) **Spouse is not offered medical coverage by their employer OR**
b) **Medical coverage premium for the lowest cost plan, paid by the spouse, is over $200 per month for single coverage, OR**
c) **Spouse is self-employed, disabled, retired, unemployed, or a WellSpan employee**

Please Note: If your spouse is employed, the **Employer Section** below must be completed by an authorized representative of their employer. If the employer's response below indicates your spouse IS offered medical coverage and the cost is less than $200 per month for single coverage, your spouse may only be covered on your WellSpan medical plan as SECONDARY coverage and must enroll in their employer medical plan.

WellSpan Employee Signature:

I certify the statements made on this document are true, complete, and accurate to the best of my knowledge. I agree to notify WellSpan in the event any of the facts or information provided on this form changes due to a change in my spouse's employment and/or medical insurance status.

Signature:_____ Date Signed: _____ Effective: _____

(Electronic Signature: My typed name above shall have the same force and effect as my written signature.)

Employer Section:
(To be completed by an authorized representative of the employer of the above-named spouse of a WellSpan employee.)

Is medical coverage available to your employee listed above?

◯ **No**

◯ **Yes:**

If coverage is available, does the employee pay less than $200 per month for the lowest cost employee only medical plan?

◯ **No** ◯ **Yes** ** If yes is checked, Spouse MUST enroll in employer plan.**

Please Note: *Due to federal regulation, individuals CANNOT be enrolled in a* ***High Deductible Health Plan (HDHP)*** *with an HSA contributed to by the employee and/or employer and be enrolled in a PPO (WellSpan Plus or WellSpan Standard) plan.*

Employer Name:

Employer Address:

Name & Title of Authorized Employer Representative completing this form (please print):

Telephone & Email Address of Authorized Employer Representative completing form (please print):

Form Submission: Upload document to Oracle from "Pending Actions" **Questions:** (717) 851-5959 *Revised 01/2024*