2024 Spousal Eligibility Certificate

Side One

Union County Health Insurance Benefits Plan
Annual Eligibility Certification

Union County's Coordination of Benefits requires spouses of covered employees to join their Employer's group health plan for primary coverage where such availability to coverage exists. Spouse's coverage will not be granted until this Certificate is completed and returned to the Human Resource Department during open enrollment of each year. Secondary coverage for spouses is not permitted under the county's plan.

Union County Employee Name _____ SSN# (last 4 digits) _____
(print)

Department Name_____ Phone # _____

Please check the one item that qualifies the employee's spouse as eligible for coverage as a dependent on Union County's Health Insurance Plan:

☐ 1. My spouse is *self*-employed and does not currently have access to a group medical plan.

☐ 2. My spouse is employed and my spouse's Employer does NOT offer medical coverage for my spouse or my spouse does not meet his/her Employer's medical insurance eligibility requirements.

☐ 3. My spouse is retired, is not actively employed, and does not have access to a group medical/dental/prescription plan through a public/private retirement plan.

☐ 4. My spouse is also employed by Union County.

☐ 5. My spouse is not employed.

AFFIDAVIT: I understand that my spouse must meet the eligibility requirements to qualify for enrollment as my dependent in the Union County Health Insurance Benefits Plan. I attest that the facts above are true and correct to the best of my knowledge and indicate this by my signature below. I understand that if my spouse's coverage status changes, it is my obligation to inform the Human Resource Department within 30 days of any change. Any false statements as it relates to this information shall be considered grounds for disciplinary action.

Employee's Signature: _____ **Date:** _____

If Item 2 above is checked above, the county employee, spouse and spouse's Employer shall complete Side 2 of the Certificate before a request for spousal coverage will be granted.

Side Two

2024 Spousal Eligibility Certificate

Union County Employees Health Insurance Benefits Plan
Annual Eligibility Certification

SPOUSE EMPLOYER VERIFICATION OF COVERAGE

If Item 2 of Side 1 of the Spousal Eligibility Certificate is checked, the county employee (box 1), spouse (box 2) and spouse's Employer (box 3) shall complete Side 2 of the Certificate before a request for spousal coverage will be granted.

Union County Employee Name:_____ **SSN# (last 4 digits):** _____
(printed)

Department Name:_____ **Phone#**: _____

I authorize my Employer to release the health care plan coverage information requested below.

Spouse name (printed): _____

Spouse Signature:_____ **Date:** _____

To be completed by the Spouse's Authorized Employer Contact:

The Union County medical plan covering your employee's spouse requires spouses eligible for coverage under another Employer-sponsored plan to take that coverage as primary.

Does your company offer an Employer-sponsored health insurance plan? ☐ Yes ☐ No

Is this employee (identified above in the second box) eligible for Employer-sponsored health insurance coverage with your company? ☐ Yes ☐ No

Note: If both answers are marked yes, then the employee's spouse shall not be eligible for coverage under the Union County medical plan.

Please complete the following, as applicable:

Company Health Insurance Carrier: _____

Coverage (circle one): None Individual Family Other: _____ Effective Date: _____

Employer Name: _____ Phone: _____

Authorized Employer Contact Signature: _____ Date: _____

Printed Name and Title: _____

If you have questions, please contact the Human Resources Department (645-3106).
Please return this form to: Fax: 937-645-3072; Email: HR@unioncountyohio.gov