Union County Health Insurance Annual Eligibility Certification for Plan Year 2025 Spousal Eligibility Certificate

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. Participation of spouses in the County's CEBCO health insurance program is limited to the instances described below. Employee requests to add their spouse to their health insurance will not be considered until this Certificate is completed in its entirety and returned to the Human Resources Department during open enrollment of each year.

Union County Employee Name:	
(print)	
Department Name:	Phone:
Please check the one item that qualifies the employee's spouse as eligible for on Union County's Health Insurance Plan:	coverage as a dependent
\Box 1. My spouse is <i>self</i> -employed and does not currently have access to a gro	oup medical plan.
☐ 2. My spouse is employed and my spouse's Employer does NOT offer medor my spouse does not meet his/her Employer's medical insurance eligible.	
\square 3. My spouse is also employed by Union County.	
☐ 4. My spouse is not employed.	
AFFIDAVIT : I understand that my spouse must meet the eligibility requirement as my dependent in the Union County Health Insurance Benefits Plan. I attest and correct to the best of my knowledge and indicate this by my signature be spouse's coverage status changes, it is my obligation to inform the Human R 30 days of any change. Any false statements as it relates to this information for disciplinary action.	that the facts above are true clow. I understand that if my desources Department within
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 in order for the employee's request for spousal coverage to be considered.

Union County Employees Health Insurance Benefits Plan Annual Eligibility Certification for Plan Year 2025 Spousal Eligibility Certificate

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):	
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 p	olan? 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 the Union County medical plan.	shall not be eligible for coverage under	
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:		