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Spouse Eligibility Form

Note: Every item must be completed before eligibility can be processed/confirmed! (please print in ink or type)

Plan Name: _____

Enrollee Name: _____ ID/SSN #: _____

Spouse Name: _____ Soc Sec #: _____ Date of Birth: _____

Employment Based Healthcare Coverage

Is the spouse employed? ❍ *Yes* ❍ *No*

Name of employer: _____ Address: _____

City, State, Zip Code: _____ Telephone #: _____

Does this employer offer healthcare coverage? ❍ *Yes* ❍ *No*
If so, is spouse eligible for this coverage? ❍ *Yes* ❍ *No*
If not, why not? ❍ *Working part-time* ❍ *No Open Enrollment Period*
❍ Open Enrollment Period already passed ❍ *Other*_____
If eligible, has spouse enrolled in this coverage? ❍ *Yes* ❍ *No* ❍ *N/A, not eligible*

Student Healthcare Coverage

Is the spouse a student? ❍ *Yes* ❍ *No*

Name of school: _____ Address: _____

City, State, Zip Code: _____ Telephone #: _____

Is spouse eligible for coverage as a student? ❍ *Yes* ❍ *No*
If eligible, has spouse enrolled in this coverage? ❍ *Yes* ❍ *No* ❍ *N/A, not eligible*

Healthcare Coverage Information

If any family members are enrolled in any healthcare coverage (including employer provided coverage, private insurance, student insurance, COBRA, Medicare, and Medicaid), please provide details below.

Plan Name: _____ Plan #: _____

Plan Address: _____

Plan City, State, Zip Code: _____

Policy # or Enrollee ID #: _____ Plan Telephone #: _____

Family member(s) covered under Plan: _____
If there is more than one plan providing other coverage, provide additional information on the back of this form.

I hereby certify that the above answers are true and complete to the best of my knowledge and are the basis under which benefits are provided under this Plan.

_____ _____
Signature of Spouse Date

_____ _____
Signature of Enrollee Date