OTTAWA COUNTY - SPOUSE COVERAGE FORM

Any employee who is married and enrolled or enrolling in the Ottawa County Health Insurance Benefit Plan **must complete this form**. Failure to complete this form will automatically deny your spouse coverage when eligible.

Employees who are married must determine if their spouses' employer or retirement system offers a group health plan. If your spouse's employer or retirement system offers a company sponsored health insurance program, the spouse must elect coverage, in at least a single policy, under their health program if they meet their eligibility requirements. **YOUR SPOUSE WILL ONLY BE COVERED UNDER THE COUNTY'S PLAN AS SECONDARY AND MUST ENROLL IN THEIR EMPLOYER'S PLAN**. If your spouse is not working and not eligible through an employer sponsored retirement program please complete that appropriate section.

Ottawa County Employee Name _____ (please print)

Department_____ Member ID # (found on your MMOH card)_____

☐ I understand by checking this box I am waiving coverage for my spouse through the Ottawa County Health Insurance Employee Benefit Plan and do NOT need to complete the spouse employer verification of coverage section. Please sign and return to your department head.

Employee's Signature: _____ Date: _____

☐ I understand by checking this box, my spouse has primary coverage through his/her employer or retirement system and is electing to be covered secondary by Ottawa County. If they are already enrolled you may copy their current medical ID card to page 2 and return the form without the employer's verification to your department head. If your spouse is not currently enrolled please complete page 2, Employer Verification Form.

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

Please check the one item that qualifies your spouse to be eligible for **PRIMARY** coverage as a dependent on Ottawa County's Health Insurance Benefit Plan:

☐ 1. My spouse is NOT employed.
☐ 2. My spouse is retired and not eligible for employer sponsored retirement plan (must complete the verification section)
☐ 3. My spouse is *self*-employed and does not have access to a group medical plan.
☐ 4. My spouse is also employed by Ottawa County.
☐ 5. My spouse is employed and my spouse's employer does NOT offer medical coverage for my spouse or my spouse does not meet their employer's medical insurance eligibility requirements. (Must complete the employer verification section)
☐ 6. My spouse is covered under Medicare

AFFIDAVIT: I understand that my spouse must meet one of the eligibility requirements above to qualify for enrollment as a primary dependent in the Ottawa County Health Insurance Employee Benefit Plan. I certify the above information to be true and correct. I understand failure to notify my employer of my spouse's employment change or falsifying my spouse's employment status is fraud and will result in financial penalty, possible disciplinary action up to and including termination and/or loss of coverage for my spouse.

Employee's Signature: _____ Date: _____

Revised: 8/22/18

SPOUSE EMPLOYER VERIFICATION OF COVERAGE ON REVERSE SIDE

Ottawa County Member ID # (found on your MMOH card) _____

If your spouse is employed and you are requesting coverage for him/her, this form must be signed below and taken to their employer for completion of the Spouse Employer Verification section below.

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

Spouse name (printed): _____

Spouse Signature: _____ Date: _____

SPOUSE EMPLOYER VERIFICATION OF COVERAGE

The Ottawa County Health Insurance Plan does not cover your current or retired employee as primary under our employee's policy. If you offer a group policy your employee or retired employee is required to participate in a single policy. Please complete the section below.

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

Is this current employee eligible for employer-sponsored health insurance coverage with your company? ☐ Yes ☐ No

Is this RETIRED employee eligible for employer-sponsored retirement coverage? ☐ Yes ☐ No

If this employee is currently covered or has enrolled in the employer-sponsored plan, please complete the following:

Company Health Insurance Carrier: _____

Group Number: _____

Coverage (circle one): ☐ Individual ☐ Family ☐ Other: _____ Effective Date: _____

Is this plan a High Deductible Health Plan (HDHP – H.S.A.) ☐ Yes ☐ No

Employer Name: _____ Phone: _____

Authorized Employer Contact Signature: _____ Date: _____

Printed Name and Title: _____

Email Address: _____

Please return this form to Ottawa County Commissioners
Fax: 419-734-6898; E-mail: lkurtz@co.ottawa.oh.us
If you have questions, call 419-734-6710

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