2024 Spousal Medical Insurance Verification Form

Must be completed and return to HR within 31 days of New Hire start or a life event.WellSpan Health provides

PRIMARY medical coverage for spouses of our employees if:

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**

WellSpan Health medical insurance may be elected as SECONDARY coverage if the provisions outlined above are not applicable. **Due to federal regulation, individuals CANNOT be enrolled in a WellSpan HDHP with an HSA with employee and/or employer contributions made to the HSA plan and be enrolled in a PPO (WellSpan Plus or WellSpan Standard) plan.**

Section 1: Please complete the following if adding your spouse to WellSpan medical insurance coverage

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

My Spouse is: (Please indicate your selection below)

○ Employed, but meets criteria (a) or (b) above (sign and date form, **Spouse employer must complete Section 2**)

○ Employed, but does not any meet criteria above and **must** enroll in medical insurance with Employer.

Indicate health plan/type below, sign and date form, return to HR. If Spouse waives their Employer coverage, they cannot enroll on WellSpan's medical plan.

Name of Health Plan: _____

Type of Medical Plan (PPO, HMO, HDHP*):

If plan is a **HDHP*** is an HSA Offered: ○No ○Yes (If yes, are contributions made by spouse or their Employer? ○Yes ○No)

***Due to federal regulation, individuals CANNOT be enrolled in a HDHP with an HSA if the employee and/or employer make monetary contributions to the HSA plan, and be enrolled in a PPO plan**

○ Self-employed, Disabled, Retired, Unemployed or is a WellSpan Employee (sign and date form, return to HR) – **Section 2 below does NOT need to be completed.**

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

Employee Signature: _____ Date Signed: _____ Effective: _____

Section 2: **Spouse Employer Certification Section** (Must be completed if spouse is employed and covered on WellSpan medical insurance.) (Section to be completed by authorized representative of the above-named spouse's employer.)

Is medical coverage available to your employee? ○ **Yes** ○ **No**
If yes, is the medical premium, for the lowest cost plan, paid by the employee over $200 per month for single coverage? ○ **Yes** ○ **No*** ** If no checked, Spouse must enroll in employer 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):