SPOUSAL BENEFIT FORM

(Bottom portion to be completed by spouse's employer)

In order for spouses (one to whom you are legally married) to be covered under the Journey Health System group health insurance program, they must certify the following:

- The employee's spouse does not work full time; OR
- The employee's spouse is not eligible for his/her employer-sponsored health care benefits; OR
- The employee's spouse's employer does not offer health care benefits.

HOW TO FIND OUT IF YOUR SPOUSE IS ELIGIBLE FOR COVERAGE THROUGH US:

1. Have your spouse take the **Spousal Benefits Form** to his/her employer and have them complete and sign.
2. Bring completed form into Human Resources before the end of your eligibility waiting period. **IF YOU DO NOT RETURN THE SPOUSAL BENEFITS FORM YOUR SPOUSE WILL AUTOMATICALLY NOT BE ENROLLED IN THE PLAN. NO EXCEPTIONS.**
3. If your spouse is eligible to enroll on the Journey Health System plan you will be notified then and you need to do nothing else.
4. If you need documentation that your spouse cannot be covered, a form will be available to you in Human Resources.

Please see Human Resources if you have any questions regarding this policy.

In order for the following employee to enroll or continue dependent coverage under the Journey Health System medical insurance plan they must provide proof that they are not eligible for medical insurance at their current employer. If the employee is eligible for medical insurance benefits under their company plan, they will be considered ineligible for the Journey plan.

□ My spouse is unemployed □ My spouse is self-employed □ My spouse is also employed with an affiliate

If employed, this section must be completed by Spouse's Employer:

Spouse's Employer: _____ Date of Hire:_____

Spouse's Name: _____ Social Security #: _____

Is the above eligible for health insurance benefits in **2023**? NO YES **Effective Date: _____**

If you answered NO, please provide a brief explanation as to why they are not eligible: _____

If you answered YES, please provide the Insurance Company's Name: _____

_____ _____

Print Name of **Employer Representative** **Employer Representative** Signature / Date

I affirm this form has been completed to the best of my information, knowledge and belief. I agree to notify Journey Health System Human Resources immediately if any above circumstances change (i.e., marriage, divorce, spouse becomes eligible for coverage elsewhere, etc.) I understand my failure to notify Journey Health System of any change in eligibility status, or misrepresentation may constitute a criminal offense and/or disciplinary action up to and including termination of employment.

□ A copy of my marriage license is already on file.
□ Attached is a copy of my marriage license (Note: This is required if not already on file)

Employee Name (printed)		**Employee Signature**	
Spouse's Name (printed)		**Spouse's Signature**	