SPOUSAL EMPLOYER VERIFICATION FORM

Ohio Healthcare Plan requires spouses of covered employees to join their employer's group health plan, for at least a single/individual coverage, where such eligibility to coverage exists. In order for your employee to be considered for medical coverage with Ohio Healthcare Plan this form must be completed and returned by the employee.

To be Completed by Member (This section MUST be completed).		
Member Name:		
Spouse's Name:		
Spouse's Date of Birth:		
To be Completed by Spouse's Employer		
Company Name:		
Company Address:		
Our Company's Health Plan year ends on: _____ (Example: Dec 31, XXXX)		
☐	My employee **is** eligible for medical coverage through our organization.	*If checked, this employee must enroll in primary coverage through your employer-sponsored medical plan, for at least individual coverage.*
☐	My employee **is** eligible for a stipend for health coverage. Stipend Amount: $_____	*If checked, this employee must enroll in primary coverage elsewhere and is only eligible for secondary coverage with OHP.*
☐	My employee **is not** eligible for medical coverage through our organization. **Reason not eligible**: _____	*If checked, this employee is **NOT** required to enroll in your employer-sponsored medical plan, as long as this situation applies.*
☐	My employee **is** eligible for our employer-sponsored medical plan and would have to pay **more than 50 percent** of the total premium rate for their individual/single rate. This would be **50%** of the lowest cost plan. ** See below—must be filled in	*If checked, this employee is **NOT** required to enroll in your employer-sponsored or retiree medical plan, as long as this situation applies.*
*Single Plan Premium Employer Share $ _____ Employee Share $ _____ NOTE: Total Premium rate **shall not** include any incentives paid to waive coverage or to increase compensation.		

Employer Information (Complete this section ONLY if your employee has coverage through your organization).

Other Insurance Information	Medical Carrier	RX Carrier (if different from Medical)
Insurance Company Name		
Insurance Company Address		
Group Policy Number		
Type of Policy (PPO, HDHP/HSA, EPO or HMO)		
Effective Date		
Coverage Type	Employee Only ☐ Family ☐	Employee Only ☐ Family ☐

Dependents Covered Under Above Policy

NOTE: Falsifying employment status is fraud and will result in financial penalty and/or loss of coverage for the spouse covered under OHP. Falsifying information may also be prosecuted to the fullest extent of the law.

The above responses are correct to the best of my knowledge.

_____ _____

Employer or Employer's Representative Signature Date Phone Number EXT.

Ohio Healthcare Plan
Central Division of OHI

Employee may upload this document on the enrollment site https://ohp.benelogic.com.
You may also fax to 419-267-5262

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