SPOUSAL EMPLOYER VERIFICATION FORM

Butler Health Plan requires spouses of covered employees that are eligible/entitled to other coverage through their employer-sponsored medical plan or retiree plan to enroll in that coverage, on at least an individual basis as their own "primary" insurance. In order for a spouse to be considered for medical coverage with Butler Health 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 retiree health plan.	*If checked, this employee must enroll in primary coverage through your retiree health 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 coveage elsewhere and is only eligible for secondary coverage with BHP.***
☐	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 or retiree medical plan and would have to pay **more than 55 %** of the total premium rate for their individual/single rate. This would be more than 55% of your lowest cost plan. *(see below)	*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 Insurance 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 BHP. Falsifying information may also be prosecuted to the fullest extent of the law.

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

_____
Print Name

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

BUTLER Health PLAN
SW Division of OHI

Employee may upload this document on the enrollment site https://butlerhealthplan.benelogic.com or return to your Treasurer or Personnel Office.

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