Warren County
Educational Service Center

WARREN COUNTY EDUCATIONAL SERVICE CENTER
SPOUSAL COVERAGE VERIFICATION FORM

Section 1 - *Employee Disclosure*

(to be completed by WARREN COUNTY EDUCATIONAL SERVICE CENTER EMPLOYEE):

Are you married? ☐ Yes ☐ No

If married, is your spouse employed ☐ Yes ☐ No ☐ Self-Employed

If you are not married, or if your spouse is not employed, or is self-employed without a group plan, complete your name, signature and date below and return this form to Human Resource Department.

If your spouse is employed, compete your name, signature and date below and complete both Section 2 and Section 3.

I hereby acknowledge that the information provided on this form is accurate and that I will promptly advise Warren County Educational Service Center of my change in my spouse's employment or health insurance eligibility status.

Employee Name _____ Employee Signature _____ Date _____

Section 2 – Spousal Release

(to be completed by EMPLOYED SPOUSE):

Spouse's Name _____ Spouse's Social Security Number _____

I authorize my employer to release to Warren County Educational Service Center the information requested on this form.

Spouse's Signature _____ Date _____

Section 3 – Employer Disclosure
(to be completed by SPOUSES'S EMPLOYER):

Please complete the following applicable information regarding your employee:

Do you offer health insurance coverage to your employees?	☐ Yes	☐ No
Is the employee eligible for your company provided health insurance plan?	☐ Yes	☐ No
If yes, is employee currently covered under your health insurance plan?	☐ Yes	☐ No
Do you pay more than 50% of the monthly cost for this employee?	☐ Yes	☐ No *

*If no was selected above, please provide supporting plan documentation with this form (i.e. monthly plan premium costs and employer/employee contribution amounts.)

If employee is not currently covered under your plan, please indicate the next enrollment period during which the employee would be eligible to enroll: from _____ to _____ with coverage effective on _____

Employer Name _____ Name/Title of Company Benefits Representative _____ Phone Number _____

Address _____ Signature of Company Representative _____ Date _____

PLEASE FAX THIS FORM TO WARREN COUNTY EDUCATIONAL SERVICE CENTER ATTN: HUMAN RESOURCES FAX - 513-695-2961
ATTN: Dee - HUMAN RESOURCES DEPARTMENT
IF YOU HAVE ANY QUESTIONS PLEASE CALL 513-695-2900 EX 2920
PLEASE COMPLETE AND RETURN WITHIN 10 DAYS OF RECEIPT
revised 7/2022