Fayette County Board of Developmental Disabilities Verification for Spouse Medical Insurance Coverage

In order to obtain coverage under the Board's insurance plan, spouses must complete the following, regardless of employment status. Working spouses, who are eligible for health coverage through their employer, are required to enroll in their employer-sponsored health plan before enrolling in the Board's health plan.

Spouse: Please select the section below that best applies to your situation.

☐ I do not have or no longer have group health coverage other than Board's plan.

Please select ONE box below to best describe why you do not have coverage.

☐ I am not or am no longer employed. Last day worked:_____

☐ I am self-employed. Name and Type of Business:_____

☐ I am employed, but do not have coverage on my employer's health plan for the reason indicated below:

A. ☐ I will be eligible for coverage on:_____
B. ☐ I am an employee currently in a "waiting period." Coverage will begin on:_____
C. ☐ I am employed 30hrs or less a week.
D. ☐ My employer does not offer health coverage.
E. ☐ Other: Please Explain_____

Employer Verification: Must be completed by the Spouse's employer if Box A-E is selected.

Employer Name:_____

I hereby certify the person on this form is an employee of the Employer above and the information supplied by the employee is accurate and complete to the best of my knowledge.

Employer Representative Signature:_____ Date:_____

Employer Representative (Please print) _____Position: _____ Phone:_____

Member/Spouse Signature and Authorization (Both must sign)

I understand this election coverage is effective January 1, 2026 through December 31, 2026. We hereby declare under penalty of perjury that we are legally married and the information on this form is correct and complete to the best of our knowledge. We authorize Fayette County Board of Developmental Disabilities to verify the spouse's employment status as needed. If requested by FCBDD, we agree to obtain and furnish a copy of any marriage certificate, divorce decree, or other relevant document. We understand that if any incorrect or misleading information results in a loss to FCBDD, the Board is entitled to recover the amount of such loss from us or by withholding from our future benefits.

Employed Spouses Only: I hereby authorize my employer or other entities to release information regarding my employer's health insurance plan and my eligibility status for coverage under that plan to the FCBDD.

Employee Signature Date

Spouse Signature Date