

**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, complete 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
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Section 2 – Spousal Release

(to be completed by EMPLOYED SPOUSE):

Spouse's Name	Spouse's Social Security Number
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I authorize my employer to release to Warren County Educational Service Center the information requested on this form.

Spouse's Signature	Date
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Section 3 – Employer Disclosure

(to be completed by SPOUSES'S EMPLOYER):

Warren County Educational Service Center has payroll contribution tiers for spouses of the Warren County Educational Service Center who waive health care coverage under their employer's plan, if their employer pays at least 50% of the monthly cost of the health coverage. The information you provide below will assist in applying this policy.

Please complete the following applicable information regarding your employee:

Do you offer health insurance coverage to your employees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the employee eligible for your company provided health insurance plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, is employee currently covered under your health insurance plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you pay more than 50% of the monthly cost for this employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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
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Address	Signature of Company Representative	Date
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PLEASE FAX THIS FORM TO WARREN COUNTY EDUCATIONAL SERVICE CENTER ATTN: HUMAN RESOURCES FAX - 513-695-2961

ATTN: HUMAN RESOURCES DEPARTMENT

IF YOU HAVE ANY QUESTIONS PLEASE CALL 513-695-2900 EX 2920

PLEASE COMPLETE AND RETURN WITHIN 10 DAYS OF RECEIPT