

SPOUSE MEDICAL INSURANCE COVERAGE STATEMENT

The Bellin Health medical plan contains a Spouse Medical Insurance Coverage Statement, which requires that an employee’s spouse either take at least single medical coverage through his/her employer to serve as his/her primary insurance coverage, or pay an additional fee for spouse to enroll in Bellin’s medical coverage as primary coverage.

Bellin Employee: Please complete Part I. Your spouse’s employer (if applicable) needs to complete Part II.

PART I. (To be completed by Bellin Employee.)

Name: _____ Employee Social Security #: XXX-XX-_____
(Please print)

Spouse Name: _____ Spouse Social Security #: _____
(Please print)

- My spouse is unemployed at this time.
- My spouse is retired.
- My spouse is self-employed and doesn’t offer group coverage to his/her employees.
- My spouse is a Bellin Health employee.
- My spouse is currently employed, see Part II below.

I hereby certify that the information contained on this form is true and correct. I understand that Bellin Health reserves the right to verify the information provided on this form by contacting my spouse’s employer. I also understand that if my spouse becomes eligible for medical coverage from his/her employer during the plan year, I must notify Bellin Human Resources of this change within 30 days.

Employee Signature: _____ Date: _____

PART II. (To be completed by spouse’s employer, if applicable.)

Company Name: _____

Please check all that apply:

- ___ The above named “spouse” is employed at this company.
- ___ The above named “spouse” is eligible for medical coverage, and is currently enrolled in employer’s medical insurance.
- ___ The above named “spouse” is eligible for medical coverage, but is not currently enrolled in employer’s medical insurance.
- ___ The above named “spouse” is not eligible for medical coverage at this time because *(please state reason or attach letter)*. _____

Date employee may apply for coverage again: _____

___ No health insurance coverage is offered by employer.

Signature of “spouse” employer *(Must be completed if Part II. was completed)*

Name of person completing this form: _____
(Please print)

Signed: _____ Date: _____

Title: _____ Phone Number: _____

Email address: _____

THIS FORM MAY BE SENT OR FAXED TO BELLIN HUMAN RESOURCE MANAGEMENT DEPT. :
PO Box 23400, Green Bay WI 54305-3400 or Fax Number : (920) 445-7249

Please note: If a form is not returned by November 20, 2009 and your spouse will be on the medical plan for 2010, the additional fee of \$65 per pay period will be taken.