Spousal Evidence of Eligibility for Participation in the Wittenberg Medical Plan

Per Wittenberg's policy, spouses that have medical coverage available through their own employers are not eligible for coverage under the Wittenberg medical plan(s). This Evidence of Eligibility form must be completed by employees who wish to enroll in +Spouse OR +Family coverage levels.

Eligibility Questions

1. Is your spouse currently employed with another employer?

   ☐ **YES.** Please provide name and phone number of Employer then continue to question 2 below.

   _____ _____
   (Employer Name) (Employer Phone)

   ☐ **NO.** Please see the Eligibility Determination section and the Disclaimer & Certification section.

2. Does your spouse's employer offer medical insurance? If so, is your spouse eligible to enroll in that medical insurance?

   ☐ **2(a): NO.** My spouse's employer does not offer medical insurance.

   ☐ **2(b): YES**. However, my spouse is not eligible for coverage through their employer plan. Please provide the reason for non-eligibility here: (ex: part-time status, ineligible class, etc.)

   _____

   ☐ **2(c): YES.** However, my spouse is not eligible for coverage through their employer plan until the effective date listed here: _____.

   ☐ **2(d): YES.** My spouse is enrolled, or will enroll, in their employer plan. Please provide name of plan and effective date of coverage.

   _____ _____
   (Name of Plan) (Effective Date)

Eligibility Determination

- **<u>If you answered "No" to questions 1 or 2(a) *OR* "Yes" to question 2(b):</u>** Your spouse remains eligible to enroll in the Wittenberg plan and can be enrolled, if desired.
- **<u>If you answered "Yes" to question 2(c):</u>** Your spouse may enroll in the Wittenberg plan ***only until the effective date listed in 2(c),*** after which time they must obtain coverage through their own employer plan (or marketplace plan if they don't want their own employer's coverage).
- **<u>If you answered "Yes" to question 2(d)</u>**: Your spouse is ***not eligible*** to enroll in Wittenberg's medical plan and must obtain coverage through their own employer plan (or marketplace plan if they don't want their own employer's coverage).

Disclaimer & Signed Certification

IMPORTANT NOTE: ***All employees who wish to enroll in either +Spouse or +Family coverage levels must submit a completed Spousal Evidence of Eligibility form to the Human Resources department. Failure to do so will result in non-coverage for your spouse and/or other dependents.***

Wittenberg reserves the right to contact employers listed on this form to verify eligibility of your spouse's medical coverage. Discrepancies could result in termination of coverage from the Wittenberg plan for you and/or your spouse.

Your signature below certifies that this information is true and correct to the best of your knowledge. You also certify that if this information changes (i.e. your spouse changes employers, your spouse becomes eligible for coverage through their current employer, or other scenarios affecting your spouse's coverage) you will promptly notify the Wittenberg Human Resources department.

Employee Name (please print): _____

Spouse's Name (please print): _____

_____ _____

Employee's Signature Date Signed

_____ _____

Human Resources Signature Date Signed