City of Lebanon
Human Resources and Payroll
PH: 615-443-2809

Employer Verification Form for Spouse's Health Insurance

Employee Name **Employee Payroll ID**

Spouse's Name

Spouse's Employer

I understand this form must be completed in order to cover my spouse on my City of Lebanon Group Health Insurance plan. This form is used to determine a spouse's eligibility to receive City of Lebanon health benefits. Generally, the following spouses are eligible to be covered by the City's medical insurance without a "spousal premium" if the

- ☐ Spouse is **not** employed.
- ☐ Spouse whose employer does **not** offer medical coverage,
- ☐ Spouse who is **not** eligible to participate in their employer's medical coverage

The 2023/2024 plan year Spousal premium is $200 ($100 bi-weekly). I understand by signing this form that if my spouse has health coverage available through his/her employer and I elect to enroll my spouse on to the City's health plan that I will be required to pay this additional premium.

I acknowledge that $100 per pay period will be deducted from my payroll check for a total of $200 monthly for the spousal surcharge.

By signing below, I acknowledge if any of this information changes, I must complete a new form within 30 days and understand if any false information is made or information withheld, The City of Lebanon will have the right to recover any overpayment and recoup any legal fees incurred and health insurance coverage and my employment may be terminated immediately.

City of Lebanon Employee Signature ***Date***

Spouse's Authorization to Release Information
I hereby authorize my employer to release the information requested below. I also understand that if there is any change in this information I must notify City of Lebanon immediately, but not to exceed 30 days of the change.

Spouse's Signature ***Date***

THIS SECTION MUST BE COMPLETED BY THE SPOUSE'S EMPLOYER HUMAN RESOURCES OR OTHER AUTHORIZED REPRESENTATIVE.

Employer Name and Address, City, State, ZIP

Does your company offer health insurance benefits to employees?

- ☐ YES
- ☐ NO, skip to end and sign below

Is above named employee eligible for your company's health insurance benefits?

- ☐ YES
- ☐ NO

If No, are they in an enrollment waiting period?

- ☐ YES, when are they eligible to enroll? _____
- ☐ NO

Dates of your company's open enrollment: _____

Print Name and Job Title of authorized person completing form

Signature **Date**