Spouse Other Coverage Information Form

If your spouse is **eligible** for other health care coverage **through an employer plan**, regardless if they are currently enrolled or the cost, he or she must enroll in that coverage.

If your spouse's employer does not offer health care coverage or if your spouse is not eligible for coverage through their employer, you will need to complete this form, along with your enrollment application. If your spouse is unemployed, self-employed, retired, etc., and does not have coverage, you must complete the form and certify that no other coverage is available.

It is the employee's responsibility to notify Drury University if their spouse gains other coverage through their employer. If Drury University learns that your spouse is covered under Drury's health care plan and has other coverage available and you do not notify Drury University or refuse to take the available coverage, your spouse will no longer be covered under the Drury health plan as of the date he or she was **eligible** for the other coverage. In addition, benefits will be backdated to the date your spouse could have enrolled for such other coverage.

Employee Last Name: ______________________ *First Name:* ___________________________

Employee ID #: _________________________

Spouse Last Name: _______________________ *First Name:* _________________

Spouse Employer: ____

Is other coverage available through spouse's employer? (circle one) *Yes* *No*

By signing this form, you certify that the information you have provided is true, accurate, and complete and you are providing the information to be relied upon by the Plan Administrator. Falsification of any of the information provided to the Plan Administrator may result in your termination from coverage under the Plan, or termination of the coverage of your spouse. The Plan also reserves the right to demand reimbursement for benefits paid to you or anyone receiving benefits through you based on falsified claims.

I also understand that if my spouse's group health insurance status changes, it is my responsibility to notify the Human Resources Benefits Office within 31 days of such change.

__________________________________ __________________________

Employee Signature ***Date***