2015 Spouse Health Plan Eligibility Verification Form

Our records indicate that your spouse is employed and is a dependent on the Jurgensen Companies Medical Plan. Please complete the form and return by **January 16, 2015**

JURGENSEN COMPANIES
INFRASTRUCTURE SOLUTIONS

EMPLOYEE/SUBSCRIBER INFORMATION

Employee/Subscriber Last Name First Name MI

SPOUSE INFORMATION

Spouse Last Name First name MI

Spouse's Employer Name:

Address of Employer:

SPOUSE ELIGIBILITY

A spouse must not be eligible for his/her own employer group coverage, if the coverage meets the "affordable and minimum essential services" requirements.

EMPLOYEE/SUBSCRIBER CERTIFICATION

By signing below, I attest that all information provided is accurate and I fully understand the spouse eligibility requirements. I understand that failure to notify the benefits department at Jurgensen of my spouse's employment change or falsifying employment status is fraud and could result in financial penalty, loss of coverage, and separation of employment. I further certify that if my spouse later becomes eligibile for group health coverage through his/her employer, I am responsible for notifying the benefits department within 30 calendar days following the date of eligibility. It is also acknowleged that if I become divorced from the individual that I will notify the benefits department within 30 calendar days following the event date to remove the individual and any children that are no longer my legal dependents as a result of the divorce.

_____ _____

Employee Signature Date

EMPLOYER CERTIFICATION

The Jurgensen Companies has a Spouse Eligibility Rule which excludes from eligibility for coverage under the Jurgensen Companies Medical Plan any spouse of a Jurgensen Companies employee who is employed and is eligible for health plan coverage by or through contributions provided by such spousal employer.

Please complete the following applicable information on your employee:

☐ We offer medical insurance and this employee is eligible.
Date coverage began or will begin: _____

☐ We offer medical insurance but this employee is not eligible to enroll because:

_____

☐ We do not offer medical insurance.

Employer Name: _____

Signature of Company Benefits Representative: _____

Printed Name of Company Benefits Representative: _____

Phone Number: _____ Date: _____

Employer: Please fax or email this form as soon as possible to:

Julie Franco
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