Spouse Verification of Coverage Form

This form must be completed and submitted to Human Resources during each annual enrollment and at the time of any change if you wish to enroll your spouse in your medical coverage.

- ☐ My spouse is employed and employer-sponsored group health plan coverage (other than limited group health plan coverage) **IS** available to him/her. My spouse is eligible for secondary coverage through Lochmueller Group

- ☐ My spouse is employed and employer-sponsored group health plan coverage **IS NOT** available to him/her. My spouse is eligible for **primary coverage** through Lochmueller Group.

- ☐ My spouse is currently unemployed or is self-employed and **IS NOT** eligible for coverage under any employer-sponsored group health plan coverage. My spouse is eligible for **primary coverage** through Lochmueller Group.

Affidavit: My spouse and I understand that in order for my spouse to be eligible for primary coverage under the Plan, my spouse cannot be eligible for coverage under any other employer-sponsored group health plan. **We further certify that if we fail to submit a properly signed and completed copy of this form during the open enrollment, my spouse will not be eligible for medical coverage under the Plan**. We certify the above information to be true and correct and will **promptly notify Human Resources if any eligibility changes occur throughout the plan year**. We understand that any misrepresentation made by us on this form and failure to report eligibility changes may be grounds for denial of claims, and that we may be required to reimburse the Employer for any claims paid in reliance on any misrepresentations made on this form.

Employee's Signature: _____

Spouse's Signature: _____

Date: _____

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