November 2018

Dear Employee:

Hancock County Government is continuing the policy of requiring the spouse of a non-certified health plan participant to seek coverage under his/her own employer's health plan. If you are seeking to cover your spouse under the Hancock County Government health plan, you must complete and return the enclosed form to certify his/her eligibility. **THIS FORM MUST BE COMPLETED EVERY YEAR!**

The following rules will apply:

- Coverage must be obtained for your spouse through his/her employer when available, regardless of premium. However, if the benefits offered are not a qualified group health plan as defined by the Patient Protection Affordable Care Act, an exception will be made to allow the spouse to remain on the plan. This determination will be made by an outside consultant.

- If your spouse's plan is closed to enrollment until an open enrollment period occurs, coverage can be maintained through Hancock County Government until that date. At that point your spouse is obligated to enroll in his/her employer's plan and coverage will cease under Hancock County Government's plan.

- If your spouse is able to obtain coverage at this time, but loses coverage in the future due to a HIPPA qualifying event (i.e. termination of employment, expiration of COBRA coverage, loss of employer contributions towards coverage), coverage can be obtained through Hancock County Government until new coverage is available.

Please return this completed form by November 26, 2018 to:
Hancock County Government
Attn: Mary McCoy
111 American Legion Place, Suite 217
Greenfield, IN 46140

Hancock County Government reserves the right to request additional information needed to determine a spouse's eligibility.

Hancock County Government Certification of
Spousal Eligibility (2019)

Section A. Employee Information

I. Name of Employee:_____

2. Social Security Number:_____

3. Date of Birth:_____

Section B. Spouse Information

I. Name of Spouse:_____

2. Social Security Number:_____

3. Date of Birth:_____

4. Status *(please check):* __Employed __Self-Employed __Retired __Unemployed

5. Name and address of present _____

Employer, if applicable:_____

Section C. Spousal Coverage

Is your spouse covered by another health plan other than yours? __No __Yes

If yes, please name:_____

Section D. Spousal Eligibility

If your spouse is unemployed, disregard Section "D ".

If the spouse named in Section B is not covered by a health plan offered through his/her own employer, please check the applicable box:

___ S/he is a new hire still in a waiting period. S/he will be eligible_____
___ Health Benefits are not offered to any employee in his/her employment category.
___ Other; please explain._____

Section E. Employee's Certification

I hereby certify that the information contained in Sections A-D is true and complete. **I understand that filing a statement to defraud is a criminal act.**

_____ _____

Employee's signature **Date**