CLEAR FORM

SAVE FORM

CURRENT PLAN YEAR _____

SPOUSAL HEALTHCARE

COVERAGE VERIFICATION FORM

Employee Name: _____
(please print)

☐ My spouse _____ is currently unemployed.

☐ My spouse _____ is employed/self-employed and earned less than $35,000 in the previous year of _____. (Please attach your spouse's previous year _____ form W-2.)

☐ My spouse is employed/self-employed and earns more than $35,000. I understand that they will be or have been removed from health care coverage as my dependent.

_____ _____
Signature of employee Date