Spousal Verification Form

Section 1 – Employee Coverage Spousal Statement

Employee Name_____ Employee # or SS#_____
Employee Spouse Name_____

Please choose the appropriate option:

- ☐ 1. I am not married.
- ☐ 2. I am married but I am not adding my spouse.
- ☐ 3. My spouse is not actively working.
- ☐ 4. My spouse is self-employed.
- ☐ 5. My spouse is working and has elected coverage through his/her employer as primary coverage and is enrolling in the Williamson County Medical Program as secondary coverage (Section 2 completion required).
- ☐ 6. My spouse is working and has declined coverage through his/her employer and is enrolling in the Williamson County Medical Program as primary coverage. Spousal Surcharge will apply.
- ☐ 7. My spouse is working and does not have medical coverage available through his/her employer and is enrolling in the Williamson County medical program as primary coverage (Section 2 completion required).
- ☐ 8. My spouse is also employed full-time by Williamson County Government or Board of Education and eligible for benefits.
- ☐ 9. I am exempt from paying the surcharge. My spouse has had continuous coverage on the Williamson County Medical plan since January 1, 2007.

By signing, you agree to the following:

I represent and warrant that all information provided is accurate, current and complete to the best of my knowledge. Falsification of information regarding the spouse's available coverage will result in, at a minimum, the additional premium surcharge being assessed retroactively back to the date of the spouse's enrollment in the medical benefits program and/or termination from the medical benefits program. In addition, willful provision of false information may result in disciplinary action against the employee up to and including termination.

I also understand that if the status of medical coverage for my spouse changes, it is my responsibility to notify the Williamson County Benefits Department within 30 days of the change. If the Spousal Surcharge is to be discontinued due to a change, there will be no refund of the previous Spousal Surcharge deduction if the Williamson County Benefits Department is not notified within 30 day of the change.

Signature of Williamson County Employee_____ Date_____

Section 2 -Employer Coverage Spousal Statement

The intent of this statement is to verify eligibility of a spouse as a dependent under the Williamson County Benefit Plan. The individual delivering this statement to you is a spouse of Williamson County employee and has been asked to confirm the availability of health coverage (if any) from his/her current employer.

Section 2 is to be completed by the spouse's employer, and will be used by Williamson County solely for purposes of eligibility. Failure to provide the requested information will result in the Williamson County Employee having to pay a higher deduction for the spouse's enrollment in the medical plan.

Name and Address of Spouse's Employer: _____

_____

Name of individual subject of this statement (your employee): _____

- ☐ Is covered under the Company sponsored medical plan and was effective _____/_____/_____
- ☐ No medical coverage is offered by the Employer
- ☐ Is eligible but not enrolled in the Company sponsored medical plan
- ☐ Is not eligible to participate in the Company sponsored medical plan:
  Reason:_____

Contact information of person completing this form on behalf of Spouse's Employer:

Name: _____ Title: _____

Email address:_____
Phone number:_____Date:_____

Return completed form by email or USPS to:
LeAyn Barnhill
leayn.barnhill@williamsoncounty-tn.gov
Williamson County Benefits Department
ATTN: LeAyn Barnhill
1320 West Main Street, Suite 204
Franklin, TN 37064