MID-VALLEY SPECIAL EDUCATION COOPERATIVE *SPOUSAL INSURANCE INQUIRY FORM

Please return completed form to Karin Alber at the Administration Office

DATE: ______________________

SUBSCRIBERS NAME:(Please Print Your Name Here)__________________________________

☐ **My spouse is not employed/is self-employed/or is employed less than 30 hours per week.**

☐ **My spouse is employed by Mid-Valley.**

Signature of Subscriber: _________________________________ **Date:** __________________________

☐ **My spouse is employed full-time**

NAME OF SPOUSE: ____

TO BE COMPLETED BY THE ABOVE LISTED DEPENDENT:

I authorize my employer to release this information on my behalf.

Signature of spouse: _________________________________ Date: __________________

TO BE COMPLETED BY THE ABOVE LISTED SPOUSE'S EMPLOYER:

Dear Employer,
Your cooperation is required to assist in the review of your employee's access to insurance coverage.

Please check ONE appropriate answer:

- ☐ We offer group medical coverage and this employee is enrolled.
- ☐ We do not offer group medical coverage to our employees.
- ☐ We offer group medical coverage and this employee was eligible but did not enroll.
- ☐ We offer group medical coverage but this is a new employee who will be eligible on __/__/__.
- ☐ We offer group medical coverage but this employee is not eligible because ______________________.
  (Please explain)

My signature is confirmation that the group benefit plan information I have provided above is true and accurate.

Signature of employer representative: __________________________________ Date: _______________
Print representative name: __________________________________ Title: _________________________
Print employer name: _____________________________________ Business Phone (___) ___________
Address ____City______________State___Zip________

Questions? Please call Karin Alber at 331-228-5964

***This form will need to be completed ONLY if your spouse is listed on your Medical/Vision benefits.**