Verification of Employer-Sponsored Health Coverage

INSTRUCTIONS: Complete and sign this form if you are covered under another employer- sponsored health plan and you wish to receive the waiver credit from Montgomery County.

Employee Name: ______________________________ Employee ID#: ___________________________

Name of Subscriber: ___________________________ Name of Employer: ________________________

Insurance carrier _______________________ Group. No. _________ Policy No. __________________

Supporting documentation must be provided to enroll in the Waiver plan and receive the waiver credit. Please submit one of the following as proof of current coverage:

1) Letter from employer on their letterhead verifying current coverage;
2) Insurance card with your name, the employer's name, and effective date of coverage; or
3) Printout from insurance website showing your name as a covered dependent, the employer's name, and the effective date of coverage.

WAIVER CREDIT AMOUNTS:
Employee only $57.50 per month
Employee + Child(ren) $90.00 per month
Employee + Spouse $100.00 per month
Family $120.00 per month

Waiver credits are paid on the second pay of each month.

Dependent documentation, along with the dependent name, date of birth, and social security number, is required to earn a waiver credit above the employee-only amount. See Dependent Eligibility Matrix on the Benefits website at www.mcbenefit.org for a list of required documentation.

I hereby attest that the information I have supplied on this form is accurate. I understand that providing false or misleading information may result in disciplinary action, up to and including removal, and recovery of any monies wrongly paid based on this information.

Employee Signature ____ **Date** ___________________

Return completed form and proof of coverage to the Benefits Department by fax at (937) 496-7407 or email at hr@mcohio.org.