DUNN & Associates
Benefit ▪ Administrators ▪ Inc.

Working Spouse Questionnaire

Employer/Group Name: _____

Employee's Name: _____

Spouse's Name: _____

TO BE COMPLETED BY THE EMPLOYEE

Is your spouse covered by: ☐ Medicare ☐ Medicaid ☐ Tricare ☐ N/A

Is your spouse receiving Social Security Disability benefits? ☐ Yes ☐ No
Date deemed disabled: _____
Is your spouse employed? ☐ Yes ☐ No
How many hours per week does he/she work? _____
Employer's Name:_____
Is your spouse self-employed? ☐ Yes ☐ No
If yes, does he/she have access to a group medical/dental/vision plan? ☐ Yes ☐ No
Is your spouse retired and not actively employed? ☐ Yes ☐ No
Does your spouse have retiree coverage through their past employer? ☐ Yes ☐ No
Is your spouse living in the same household as you? ☐ Yes ☐ No
Is your spouse living separately from you? ☐ Yes ☐ No

If your Spouse is employed, please have your spouse's employer complete the section on the reverse side.

To the employee and spouse: I understand that my spouse's health claims will not be processed, and he/she will not receive the pharmacy copay benefit, until this form is completed and returned to Dunn and Associates. If my spouse's employment status changes in the future, I understand that I am responsible for completing a new form for spousal health coverage within 30 days of the employment status change. In addition, by my spouse's signature below, authorization is given to his/her employer to release the required information. I understand that the failure to notify my employer of my spouse's employment change or falsifying employment status is fraud and could result in financial penalty, loss of coverage, and separation of employment.

Employee's Signature: _____

Spouse's Signature: _____

Date: _____

Return completed form to: Dunn & Associates
Mail: PO Box 2369 Columbus, IN 47202-2369 – Fax (812) 378-9967 – Email: eligibility@dunnbenefit.com

***Spouse's employer must complete this page.**

***To the employer: Any person who with intent to fraud or facilitate a fraud or provide false information, may be guilty of insurance fraud.**

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Spouse's name: _____

1. Do you offer insurance benefits/coverage to your employees? ☐ Yes ☐ No

2. Is the above-mentioned spouse (your employee) eligible for benefits/coverage? ☐ Yes ☐ No

   If so, what is the first date the above-mentioned spouse was eligible: _____

3. What coverage is he/she eligible for? ☐ Medical/Drug ☐ Dental ☐ Vision

4. What coverage did he/she elect? ☐ Medical/Drug ☐ Dental ☐ Vision

5. If coverages were elected, what is the effective date of coverage under your plan? _____

Name of Employer: _____

Employer Representative Name (printed): _____

Employer Representative Title: _____

Employer Representative Email: _____

Employer's Phone #: _____

Employer Representative Name (signature): _____

Date: _____

Spouse/your employee's signature: _____

Date: _____

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