



Working Spouse Questionnaire

Employer/Group Name: City of Greensburg

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: _____

***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.**



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: _____

Return completed form to: Dunn & Associates

Mail: PO Box 2369 Columbus, IN 47202-2369 – Fax (812) 378-9967 – Email: eligibility@dunnbenefit.com