# Working Spouse Questionnaire

**Instructions:**

If your spouse is covered by your Employer's Health Plan, please return this form as soon as possible to Dunn & Associates, PO Box 2369, Columbus, IN, 47202. Thank you.

**Employee's Name**: _____

**Employer/Group Name:** _____

**Phone #:** _____

**Spouse's Name:** _____

**Spouse's Date of Birth:** _____

**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? Employer:_____ Yes ☐ No ☐

Is your Spouse retired and not actively employed? Yes ☐ No ☐

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 living in the same household as you? Yes ☐ No ☐

Is your Spouse living separately from you? Yes ☐ No ☐

Is your Spouse employed outside the home? Yes ☐ No ☐
If yes, how many hours per week does he/she work? _____

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

***To the Employee:*** 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 SECTION.**

1. Do you offer a health coverage option to your employees? Yes ☐ No ☐

**If you answered "No," you may STOP here and sign below.**

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

If so, what date is he/she eligible? _____

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

4. What coverage was elected? Medical ☐ Dental ☐ Vision ☐ Drug ☐

5. Did the above-mentioned spouse (your employee) elect coverage under your employer health plan?
Yes ☐ No ☐

If elected, what is the effective date of coverage under your plan? _____

**Name of Employer**: _____

**Phone #**: _____

**Employer Representative Name** (please print): _____

**Employer Representative Title** (please print): _____

**Employer Representative Signature**: _____

**Date**: _____

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M:Forms/2018 Updates/Working Spouse Questionnaire