MERCER COUNTY
Spouse Primary Coverage Form

PLAN YEAR 2025

Any employee electing to cover their spouse in the Mercer County Health Insurance Benefit Plan must complete this form.

Mercer County Employee Name _____ SSN# (last 4 digits) _____
(printed)

Please check the one item that qualifies your spouse as eligible for coverage as a dependent on Mercer County's Health Insurance Benefit Plan:

- ☐ 1. My spouse is NOT employed or is retired and not actively employed.
- ☐ 2. My spouse is *self*-employed and does not have access to a group medical plan.
- ☐ 3. My spouse is also employed by Mercer County.
- ☐ 4. My spouse is employed and my spouse's employer does NOT offer medical coverage for my spouse or my spouse does not meet their employer's medical insurance eligibility requirements.
- ☐ 5. My spouse is employed and has elected health benefits under his or her own employer's plan.

AFFIDAVIT: I understand that my spouse must meet one of the eligibility requirements above to qualify for enrollment as my dependent in MEBC – Mercer County Health Insurance Employee Benefit Plan. I certify the above information to be true and correct.

Employee's Signature: _____ **Date:** _____

If item 4 or 5 is checked above, the spouse must sign below and take this form to their employer for completion of the Spouse Employer Verification section below.

I authorize my employer to release the health care plan coverage information requested below.

Spouse name (printed): _____
Spouse Signature: _____ **Date:** _____

SPOUSE EMPLOYER VERIFICATION OF COVERAGE

The medical plan covering your employee's spouse requires spouses eligible for coverage under another employer-sponsored plan to take that coverage as primary.

Does your company offer an employer-sponsored health insurance plan? Yes No

Is this employee eligible for employer-sponsored health insurance coverage with your company? Yes No

If this employee is currently covered or has enrolled in the employer-sponsored plan, please complete the following:

Company Health Insurance Carrier: _____ Member ID or Group # _____

Coverage (circle one): Individual Family Other: _____ Effective Date: _____

Employer Name: _____ Phone: _____

Authorized Employer Contact Signature: _____ Date: _____

Printed Name and Title: _____

If you have questions, call 419-586-3178. Please return this form to Mercer County Commissioners.
Fax: 419-586-1699; E-mail: nancyz@mercercountyoh.gov or commmissioners@mercercountyoh.gov