INTEGRIS Health Spouse Employment Verification Form

Section 1: Benefit Verification Information – To be completed by INTEGRIS Health caregiver

Caregiver ID Number: 8000_____

Caregiver Name:	Spouse Name:	Caregiver Phone:

Is your spouse employed? Yes ☐ No ☐

If self-employed list company name and description: _____

_____

If you checked No, explain: ☐Retired ☐Disabled ☐other_____

Please sign and date Section 1 below and return to *INTEGRIS Health.*

*If you checked **Yes**, please continue to the next question.*

Is your spouse employed by INTEGRIS Health? Yes ☐ No ☐

*If you checked **Yes**, please sign and date Section 1 below and return to INTEGRIS Health.*
*If you checked **No**, please sign and date Section 1 below. Please have your spouse complete Section 2.*
If you have questions regarding this letter, document requirements, or need assistance on where to obtain requested documentation, contact INTEGRIS Health Human Resources Customer Service at 405.949.4045.

By signing below, I hereby certify and warrant to INTEGRIS Health that all information on this form is true, correct and current as of the date signed. I further understand if I knowingly submit false information I may be subject to disciplinary action, up to and including termination of employment and appropriate legal recourse. Furthermore, my signature authorizes INTEGRIS Health to verify any and all documents provided and may contact any institution or organization to verify the facts as stated herein.

Caregiver Signature: _____ Date: _____

Section 2: Information Release Authorization – To be completed by INTEGRIS Health caregiver's spouse.

I authorize the use or disclosure of the requested information for the following purpose: Healthcare eligibility information provided to INTEGRIS Health will be used solely for determination of my eligibility for coverage under an INTEGRIS Health plan sponsored by INTEGRIS Health. This authorization for release of the above information to INTEGRIS Health will expire following termination of coverage.

I understand that I am signing this authorization voluntarily and that eligibility for coverage under an INTEGRIS Health plan sponsored by INTEGRIS Health will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization will be the application of the $35.00 per pay period surcharge for enrolling a spouse that is eligible for medical coverage through their employer.

Spouse Signature: _____ Date: _____

Section 3: Employer Verification – To be completed by Spouse's employer

Please provide the following information for your employee:

Is the above listed spouse (your employee) eligible to enroll for Major Medical coverage through your company during an open enrollment or qualifying event window? Yes ☐ No ☐

Company Name: _____

HR/Benefits Contact Name: _____

Contact Title: _____

Contact Signature & Date: _____

Contact Phone Number: _____

Submit completed form to INTEGRIS Health fax at 405.979.8343 or by mailing to 3520 NW 58th St., Ste. A-100, Oklahoma City, OK 73112.
You may also email this form to BenefitForms@integrisok.com

(Form must be returned by deadline or surcharge will apply. New hire – enrollment deadline, Life Event – 30 days from date of life event, Open Enrollment – last day of open enrollment)

Failure to fully complete and return this form will result in a $35.00 per pay period surcharge deduction from your pay check.