Verification of Employer-Sponsored Health Coverage

INSTRUCTIONS: Complete and sign this form if you are covered under another employer- sponsored health plan and you wish to receive the waiver credit from Montgomery County.

Employee Name: _____ Employee ID#: _____

Name of Subscriber: _____ Name of Employer: _____

Insurance carrier _____ Group. No. _____ Policy No. _____

Supporting documentation must be provided to enroll in the Waiver plan and receive the waiver credit. Please submit one of the following as proof of current coverage:

1) Letter from employer on their letterhead verifying current coverage;
2) Insurance card with your name, the employer's name, and effective date of coverage; or
3) Printout from insurance website showing your name as a covered dependent, the employer's name, and the effective date of coverage.

I hereby attest that the information I have supplied on this form is accurate. I understand that providing false or misleading information may result in disciplinary action, up to and including removal, and recovery of any monies wrongly paid based on this information.

Employee Signature _____ **Date** _____

Return completed form and proof of coverage to the

Benefits Department

Fax (937) 496-7407

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