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 Policy Holder: _____

Name of Employer: _____ Name of Insurance: _____

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.

MONTHLY WAIVER CREDIT

Employee only	$57.50
Employee + Child(ren)*	$90.00
Employee + Spouse*	$100.00
Family*	$120.00

Waiver credits are paid on the second pay of each month.

*Dependent documentation, along with the dependent name, date of birth, and social security number, is required for these plans. See Dependent Eligibility Matrix on the Benefits website at mcbenefits.org for a list of required documentation.

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 via email to hr@mcohio.org or to the Benefits office at 451 W. Third Street, 9th Floor, Dayton, OH 45422-1340.