CATAWBA VALLEY HEALTH SYSTEM

SPOUSAL/DOMESTIC PARTNER COVERAGE INQUIRY

Employee's Name/Employee Number: ____

Our records indicate that your spouse/domestic partner is enrolled on your group health insurance plan. To properly administer this plan, we must clarify the status of your spouse in regards to eligibility for another plan. Please complete the following as coordination of benefits may apply:

Is your spouse/domestic partner currently employed? ❑Full-time ❑Part-time ❑Not employed ❑Self-Employed
If not employed, please sign and date the bottom of this form and return to the Human Resources Department. If employed Full-time or Part-time, please fill out the remainder of this form in its entirety.

1. Spouse/DP's Employer Name: ____
   Employer Address: ____
   Employer Telephone #: ____

2. Is your spouse/domestic partner eligible for health care benefits at the Employer identified above?
   ❑ No ❑ Yes

3. Is your spouse/domestic partner currently enrolled with this Employer's health care plan? ❑ Yes ❑ No
   If no, reason for not electing coverage: ____
   If yes, what is the effective date of the policy? ______/______/___________
   If yes, what benefits are covered? ❑ Medical ❑ Dental

4. If any dependents are covered under the above mentioned policy, please list their names and birthdates below:
   ____
   ____

We are pending eligibility until this information is received. Please complete the information and return it to the Human Resources Department at your earliest convenience.

Signature: ____ Date: ____/____/____