Spouse Employer Insurance Verification Form

Employee Information

Employee Name

Employee ID

Employee Phone

Employee Department

Spouse Information

Spouse Name

Spouse Date of Birth

Spouse Employer Name

Spouse Employer Phone

Insurance Information

☐ Medical Coverage Offered

☐ Medical Coverage NOT Offered

Insurance Carrier Name

Group Number

Policy Number

Coverage Effective Date

Coverage Termination Date (if applicable)

Employer Verification

Employer Representative Name

Employer Representative Title

Employer Representative Email

Employer Representative Phone

Employer Representative Signature

Date