Spousal/Domestic Partner Employment Verification Form

Employee Name _____

Employee Number or Last 4 Digits of SS#_____

Spouse/Domestic Partner Name _____

Select the applicable statement

☐ My spouse/domestic partner is employed and is eligible for medical coverage through his/her employer which meets the minimum value standard under Affordable Care Act (ACA). **My spouse/domestic partner must enroll in his/her employer's plan for primary medical coverage. Coverage under the Ardent plan will be secondary.**

☐ My spouse/domestic partner is employed, but is not eligible to participate in his/her employer's medical plan.

☐ My spouse/domestic partner is not employed or is self-employed and does not have access to coverage.

☐ My spouse/domestic partner is an Ardent Health Services employee at _____

Spouse's/Domestic Partner's Employer Contact Information

Company Name: _____

Company Address: _____

Employer Phone Number: _____

Consent Information

By signing below, I hereby certify to Ardent 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. I acknowledge that if my spouse/domestic partner is employed and has other health care coverage available, my spouse/domestic partner must enroll in his/her employer's plan for primary medical coverage. My spouse/domestic partner may be enrolled in the Ardent medical plan as secondary coverage. We authorize Ardent Health to verify my spouse's/domestic partner's employment status as needed. This consent will be valid for the entire period of my eligibility and my dependent's eligibility under the Ardent Health plans.

Employed Spouse/Domestic Partner Only: I hereby authorize my employer or other entities to release information regarding my employer's health insurance plan and my eligibility status for coverage under the plan to Ardent Health.

Employee Signature: _____ Date: _____

Spouse/Domestic Partner Signature: _____ Date: _____

Submit this form to benefitsolver within 30 days of making your benefit elections.
Information may be submitted as follows:

- Log in to your personal account at www.getardentbenefits.com/enroll.
- Click on the Message Center tab.
- View the "Action Required – Regarding your Dependent Eligibility" message.
- Scan and upload a completed copy of this form.