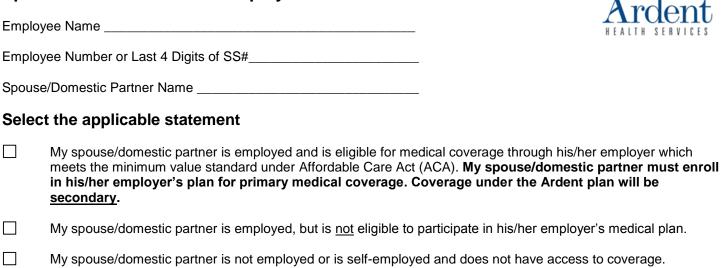
Spousal/Domestic Partner Employment Verification Form



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

 \Box

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 <u>www.getardentbenefits.com/enroll</u>.
- Click on the Message Center tab.
- o View the "Action Required Regarding your Dependent Eligibility" message.
- Scan and upload a completed copy of this form.