



Hardin County Insurance Consortium

To Whom It May Concern:

It has been indicated by our health plan participant that you are the employer of the person named below. Because of the spousal coverage provision contained in the Hardin County Insurance Consortium health plan, additional information is required to make a proper evaluation of the coverage available to your employee.

Your assistance in completing this form is appreciated.

Your Employee's Name: _____

Do you offer healthcare coverage to your employees? Yes _____ No _____

Is this employee eligible for healthcare coverage as your employee? Yes _____ No _____

Is the employee covered under your healthcare plan? Yes _____ No _____

If NO, list reason: _____

If NO, when is the earliest date the employee can enroll? _____

If YES, effective date of current coverage: _____

If YES, what **percentage** of the monthly premium will you pay for single employee coverage? _____

Name of HR Representative (Please Print) Date

Title Phone Number Email

If an employee's spouse is eligible to participate, as a current employee or retiree in group health insurance and/or prescription drug insurance sponsored by his/her employer or any public retirement plan, the spouse must enroll in such employer (or public retirement plan) sponsored group insurance coverage(s).

Please return this form by _____
Date

By Mail: OR Email: OR Fax:
Hardin Northern Local School brennon.hattery@hardinnorthern.org (419) 759-2581
Attn: Brennon Hattery
11589 State Route 81
Dola, OH 45835