

2025 Spouse Eligibility Questionnaire

Only employees electing employee plus spouse or family coverage for the 2025 plan year are required to complete this form. Both pages of the form must be completed.

To determine if your spouse is eligible for Kingston's Healthcare plan you, your spouse and your spouse's employer (if applicable) must complete both pages of the questionnaire below, provide requested documentation, and must certify that they are not eligible for any other group health plan.

Has your marital status changed since your last enrollment? ☐ Yes ☐ No

Is your spouse employed? ☐ Full-Time ☐ Part -Time ☐ Self-employed ☐ Unemployed

If your spouse **is not** currently employed list last employer, insurance at last employer, and date last insured:

If your spouse **is** employed, please list name of current employer and phone number:

Yes

No

Is your spouse eligible for group health coverage with his/her employer?

Is your spouse currently covered by his/her employer's group health plan?

Does your spouse smoke or use any tobacco products (regularly or socially)?
This includes but is not limited to cigarettes, e-cigarettes, cigars, pipes, chewing tobacco, etc.

If your spouse is employed, please have his/her employer complete the 2025 Spouse Employer Certification Form on the second page!

Certification and Signature

I (print name)_____certify that the above information is correct, and any misrepresentation(s) could result in disciplinary action up to and including termination of employment. In the event of insurance fraud, Kingston shall be reimbursed for all benefits paid.

I acknowledge that it is my responsibility to notify Kingston's Human Resources department immediately if my spouse becomes eligible for coverage at any during the year through his/her

Employee's Signature

Date

2025 Spouse Employer Certification Form

Kingston Employee Information- This section to be completed by the Kingston Employee

Employee Name

Date

Spouse Name

Date of Marriage

Authorization for Release of Information- This section to be completed by spouse even if they are not employed.

I _____ authorize my employer to release to Kingston HealthCare

Spouse Name (Print)

Company the information requested on this form.

Signature of Spouse

Date

Dear Employer,

The Kingston Medical Benefit Plan requires that a determination be made concerning the eligibility of a spouse for medical coverage. The information you provide below will help Kingston HealthCare make this determination. We appreciate your time and assistance with this matter.

This section to be completed by your spouse's employer.

Does your company offer medical insurance coverage?

Yes ☐ No ☐

Is the above spouse eligible for medical insurance coverage?

Yes ☐ No ☐

Is the above spouse currently enrolled in your company's medical insurance plan?

Yes ☐ No ☐

Employer Certification

I certify that the above information is true and correct. This section is to be completed by your spouse's employer.

Employer Name

Name of Company Representative

Signature of Company Representative

Date

Title

Phone Number

Please email this form to the Human Resources
Department of Kingston HealthCare Company at
benefits@kingstonhealthcare.com