2021 CONFIRMATION OF SPOUSE'S MEDICAL COVERAGE

This section to be completed by Republic Bank Associate			
Associate's Last Name	First	MI	**Work Location**

PLEASE THOROUGHLY READ THE PROVISIONS BELOW BEFORE SIGNING, AND CAREFULLY REVIEW FOR ERRORS OR OMISSIONS PRIOR TO SUBMISSION TO HUMAN RESOURCES.

If this form is not received by Human Resources and your spouse is enrolled in coverage under the Republic Health Plan, they will be removed from coverage until this form is received.

If your spouse loses or obtains group health coverage through his/her employer, you have 30 days to notify Human Resources of such change. Human Resources must be notified in writing of this and all "Family Status" changes within 30 days of the time the change takes place. Failure to notify Human Resources in a timely manner may restrict you from making a change until the next annual open enrollment period.

Verification of Other Employer Group Health Coverage

All associates covering a spouse under a Republic Bank medical plan must certify that they are not employed or do not have access to coverage through their own employer as a full-time employee working 30 or hours per week. The answers you provide on this form will then determine if your spouse is eligible for coverage under your medical plan provided by Republic Bank. **Please check the appropriate box that applies to you.**

(1) I certify my spouse is eligible for coverage as my dependent because of one of the following reasons:

☐ **My spouse is not employed;**

☐ **My spouse is *self-employed and not eligible for a group medical plan.**
***Provide name of business:** _____

(2) If any of the following three boxes are checked, you must submit the attached "Spouse's Employer Benefit Verification Form" to certify your spouse is not eligible for coverage through their own employer, or is not a full-time employee.

☐ **My spouse is employed but his/her employer does not offer health insurance benefits.**

☐ **My spouse is employed but is not full-time and works less that 30-hours per week.**

☐ **My spouse is employed but he/she is not eligible for health insurance benefits based on employment status (i.e. Part-time).**

REPUBLIC BANK ASSOCIATE'S CERTIFICATION

My signature below indicates the facts set forth are true and complete to the best of my knowledge. Any false statements on this form or on future forms as related to spousal health information shall be considered grounds for disciplinary action, up to and including termination of employment. I further understand that if my spouse's group medical insurance coverage status changes, it is my responsibility to notify HR and complete a new **Confirmation of Spouse Medical Coverage form** representing the updated status within 30 days.

_____ _____ _____

Print Name **Associate's Signature** **Date**

SPOUSE'S EMPLOYER BENEFIT VERIFICATION

This form must be **completed by the *employer* of the spouse** of the Republic Bank Associate (noted below) and returned to the Republic Bank Associate.

This section to be completed by Spouse's Employer			
Employee (Spouse's) Last Name First MI			**Employer Phone Number**
Employer Name			
Employer Street Address	**City**	**State**	**Zip**

1) This is to confirm that our employee (noted above) is: (Check all that apply)

(a) _____ Is a full-time employee working 30 or more hours per week; or

(b) _____ Is not full-time and works less than 30-hours per week.

-- AND --

(c) _____ Is eligible for employer-sponsored group medical coverage; or

(d) _____ Is not eligible for employer-sponsored group Medical Coverage

2) I hereby certify that the information provided above is true and complete to the best of my knowledge.

_____ _____

Print Name of Representative **Title**

_____ _____

Signature of Representative **Date**

AUTHORIZATION FOR EMPLOYER TO RELEASE INFORMATION

I hereby authorize my employer to release the above requested information to my spouse's employer, Republic Bank.

Republic Bank Associate's Name _____

_____ _____ _____

(Spouse) Print Name **Signature** **Date**