Pennsylvania Employees Benefit Trust Fund
Employer Benefit Verification Form
For Employees Hired on or After 8/1/2003

****Form must be submitted within 30 days of signature date****

The Pennsylvania Employees Benefit Trust Fund (PEBTF) administers health benefits under plans maintained for Commonwealth of Pennsylvania employees and retirees and their spouses and dependents. The member referenced below is enrolled in PEBTF health benefits as a spouse of a commonwealth employee. For employees hired on or after 8/1/03, PEBTF eligibility rules require that the spouse **must** take their own employer's health benefit coverage even if they have to pay for the coverage or if the employer offers an incentive to decline the coverage. The spouse must have primary coverage through their employer's coverage to be eligible to enroll in the applicable PEBTF medical plan, and the PEBTF plan will provide for secondary coverage.

To be completed by the PEBTF employee member Please print information below	
1. Commonwealth employee's name:	
2. Commonwealth employee number:	
3. Commonwealth employee's date of birth (mm/dd/yyyy):	
4. Spouse's name:	
5. Spouse's date of birth (mm/dd/yyyy):	
6. My spouse is employed:	☐ Full-Time ☐ Part-Time
7. My spouse is retired:	☐ Yes ☐ No
I understand that the PEBTF will rely on the information that I have provided above, and represent that, to the best of my knowledge, information, and belief, all of the information that I have provided is complete, accurate, and correct.	
8. Employee's signature:	Date:

To be completed by an authorized representative of the spouse's employer:		
1. Employer name:		
2. Is the spouse eligible for health insurance? (Incentive to decline coverage or the requirement to pay for coverage does not make the employee ineligible. If coverage is offered the employee is eligible.)	☐ Yes ☐ No (sign and date form)	
3. If yes, please indicate the date that the spouse became eligible for benefits.	Initial Eligibility Date (mm/dd/yyyy):	
4. Is the spouse currently enrolled in your organization's health plan?	☐ Yes	Effective Date of Enrollment (mm/dd/yyyy):
	☐ No	Last Date of Coverage (mm/dd/yyyy):

I understand that the PEBTF will rely on the information that I have provided above, and represent that, to the best of my knowledge, information, and belief, all of the information that I have provided is complete, accurate, and correct.

Employer Representative (print name) ____________________ Title ____________________

Employer Representative Signature ____________________ Date ____________________ Telephone Number ____________________