

**Pennsylvania Employees Benefit Trust Fund
Employer Benefit Verification Form
For Retirees, Who as Active Employees, Were 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 REHP non-Medicare health benefits as a spouse of an REHP retiree member. For retirees, who as active employees, were hired on or after 8/1/03, REHP eligibility rules require that the spouse **must** take their own employer's health benefit coverage (as an employee or retiree) 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 (as an employee or retiree) to be eligible to enroll in the applicable REHP medical plan, and the REHP plan will provide for secondary coverage.

**To be completed by the REHP retiree member
Please print information below**

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| 1. Commonwealth retiree's name: | |
| 2. Last 4 digits of retiree's Social Security Number: | |
| 3. Commonwealth retiree'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: | <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time |
| 7. My spouse is retired: | <input type="checkbox"/> Yes <input type="checkbox"/> 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. Retiree's signature: | Date: |

To be completed by an authorized representative of the spouse's employer:

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|---|---|
| 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.) | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes Effective Date of Enrollment (mm/dd/yyyy): |
| | <input type="checkbox"/> 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.

| | | |
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| Employer Representative (print name) | Title | |
| Employer Representative Signature | Date | Telephone Number |

PEBTF, 150 S. 43rd Street, Harrisburg, PA 17111