

CATHOLIC DIOCESE OF COLUMBUS
SPOUSAL EMPLOYMENT STATEMENT

This is to verify that my spouse is not eligible for or enrolled in any group health coverage and my spouse is not receiving any cash/credit from employer to purchase health coverage elsewhere (please check one):

- Group health coverage is not offered to my spouse (**must provide verification letter from spouse's employer**)
- Spouse is self-employed (**Must provide some type of verification of self-employment, i.e., letterhead, invoice, business card, etc.**)
- Spouse is not employed
- Spouse is also employed by the Diocese
- Spouse is retired
- Spouse is enrolled at his/her place of employment as primary (a copy of the spouse's group health insurance card must be attached to this form and returned to the Insurance Office at the address below to be added as secondary coverage)

Name of Spouse's Employer: _____

Address: _____ **Phone:** _____

NOTE:

The employee is responsible for notifying the appropriate individual of the Diocese for any changes that occur during the year in regards to his/her spouse's employment or benefit status before any changes will be made to this Program. If providing verification from the spouse's employer, self-employment or a spouse's health card, the Notary witness is **not** required.

I certify and confirm that this is a true statement by my signature below.

Employee Signature

Date

Witness by Notary,
STATE OF _____ COUNTY OF _____

BEFORE ME, the undersigned, a Notary Public, personally appeared

who executed the above Spousal
Employment Statement as a free and voluntary act.

IN WITNESS WHEREOF, I have signed my name and affixed my official notarial seal this
_____ day of _____, 20_____.

(SEAL)

Notary Public _____

My Commission Expires: _____

**PLEASE RETURN FORM
TO THE INSURANCE OFFICE**

Catholic Diocese of Columbus
197 East Gay Street
Columbus, OH 43215-3766
ATTN: Insurance Office
Fax: 614-241-2573