

Spouse Verification and Information Release Authorization

This Form is Only Required if Your Spouse is Employed or Self-Employed

If you are covering a spouse who is employed or self-employed, an additional step is required to complete your online verification. Please have this form completed and signed by your spouse's employer and submit as part of the verification process.

Failure to complete the spousal verification process by March 20, 2026, will result in termination of your spouse's coverage effective April 1, 2026.

Full details regarding the verification process, required documentation, guidance on obtaining the requested materials, and additional support resources are available at www.thelcsc.com/verification.

Section 1: To Be Completed by ESCWR Employee

EMPLOYEE NAME	SPOUSE NAME	EMPLOYEE PHONE
---------------	-------------	----------------

By signing below, I hereby certify that all information on this form is true, correct, and current as of the date signed. I understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of defrauding the company for insurance purposes. Penalties may include imprisonment, fines, termination, or a denial of insurance benefits. Furthermore, my signature authorizes the ESC of the Western Reserve or its representatives to verify all documents provided and contact any institution or organization to verify the facts as stated herein.

EMPLOYEE SIGNATURE: _____ DATE: _____

Section 2: To Be Completed by Your Spouse

I authorize the use or disclosure of the requested information for the purpose of verifying my healthcare eligibility. I understand this information will be used to determine my eligibility for coverage. This authorization will expire at the end of the 2026 plan year.

SPOUSE SIGNATURE: _____ DATE: _____

Section 3: To Be Completed by Your Spouse's Employer

Is the spouse (your employee) listed above eligible for medical benefits through your company? Yes No

COMPANY NAME: _____

H/R BENEFITS CONTACT NAME: _____

CONTACT TITLE: _____

CONTACT SIGNATURE: _____

SIGNATURE DATE: _____

CONTACT PHONE NUMBER: _____

CONTACT EMAIL ADDRESS: _____

Only scanned original signatures or certified digital signatures will be accepted.

Employee must submit completed form online at www.thelcsc.com/verification.