Certificate of Other Medical Coverage

Under the "HRA" sponsored by the "Employer," expenses incurred by your spouse and/or dependents are reimbursable only if your spouse and/or dependents are enrolled in a group medical plan. To the extent your spouse and/or dependents are enrolled in a group medical plan other than the Employer's group medical plan, you must sign and submit this completed form as your certification of coverage for your spouse and/or dependents. C***omplete and return this form to your Employer.***

Note: Failure to fully complete and/or submit this Certification of Other Medical Coverage will cause the HRA to deny claims submitted with respect to your spouse and dependents who are not enrolled in the Employer's group medical plan. Expenses incurred by such a spouse or dependent prior to completion and submission of this form will not be reimbursed by the HRA.

PART 1 – PARTICIPANT INFORMATION		
Name		
Address		
City	State	Zip

PART 2 – SPOUSE AND DEPENDENTS WITH OTHER COVERAGE		
Full Name of Spouse/Dependent	**Social Security Number***	**Coverage Effective Date**

*Must be provided to enable Employer to comply with the requirement to report "minimum essential coverage" to the IRS.

PART 3 – CERTIFICATION BY PARTICIPANT

- I certify that my spouse and/or dependents listed in Part 2 are or will be enrolled in a group medical plan sponsored by another employer.
- I further certify that such coverage began or will begin on the date identified in Part 2.
- I further certify and agree that if the other coverage of any individual listed in Part 2 terminates and is not replaced by coverage under another employer-sponsored group medical plan, I will notify my Employer immediately.

Signature of Participant	
Printed Name	Date

OFFICE USE ONLY – DO NOT COMPLETE	Received By	Date