Spouse / Domestic Partner
Verification and Information Release Authorization

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

If you are covering a spouse or domestic partner 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 or domestic partner's employer and submit as part of the verification process.

Failure to complete the verification process by March 20, 2026, will result in a $300/month premium surcharge.

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

Section 1: To Be Completed by SIP Employee

EMPLOYEE NAME	SPOUSE/DOMESTIC PARTNER 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 State Industrial Products 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 or Domestic Partner

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/PARTNER SIGNATURE: _____ DATE: _____

Section 3: To Be Completed by the Employer of Your Spouse or Domestic Partner

Is the spouse or domestic partner (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.sipbenefits/vertification.