

# Spouse/Partner Verification and Information Release Authorization

**THIS FORM IS ONLY REQUIRED IF YOUR SPOUSE/PARTNER IS EMPLOYED OR SELF-EMPLOYED**

If you are covering a spouse or partner who is employed or self-employed, an additional step is required with your online verification. To complete the verification process, this form must also be completed and signed by the employer of your spouse or partner.

**Failure to complete the verification process by March 20, 2026, will result in a \$300 per month spouse/partner premium surcharge beginning April 1, 2026.**

Full details regarding the verification process, required documentation, and additional support can be found online at [www.sipbenefits.com/verification](http://www.sipbenefits.com/verification).

## Section 1: To Be Completed by Employee

EMPLOYEE NAME	SPOUSE/PARTNER NAME	EMPLOYEE PHONE
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*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 my employer 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/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 and Signed by the Employer of Your Spouse or Partner

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

COMPANY NAME: \_\_\_\_\_

CONTACT NAME: \_\_\_\_\_

CONTACT TITLE: \_\_\_\_\_

CONTACT SIGNATURE: \_\_\_\_\_

SIGNATURE DATE: \_\_\_\_\_

CONTACT PHONE NUMBER: \_\_\_\_\_

CONTACT EMAIL ADDRESS: \_\_\_\_\_

*Note: Signatures must be original or certified electronic signatures. Typed or text signatures are not acceptable.*

**Employee must submit completed form online at [www.sipbenefits.com/verification](http://www.sipbenefits.com/verification).**