COUNTY OF ONONDAGA
EMPLOYEE BENEFITS
421 Montgomery Street, 15th Floor
Syracuse, NY 13202-2959

INSURANCE VERIFICATION QUESTIONNAIRE

To be completed by all retirees enrolled in the County of Onondaga Medical Plan.

Retiree Name & DOB: _____

Spouse's Name & DOB: _____

Spouse Insurance Status:

1. Is the spouse of the Onondaga County Retiree currently enrolled in ***another*** health plan?

- o Yes. Enter the name of the health carrier and subscriber id #: _____
- o No.

Spouse Employment Status:

A. Is your spouse employed?

- o Yes. Enter employer name & address: _____
- o No.

B. Is your spouse eligible to receive medical insurance offered by their current and/or former employer?

- o Yes.
- o No.

C. If your spouse's current employer or former employer offers medical coverage is your spouse enrolled?

- o Yes. Enter the name of the health carrier and subscriber id #: _____
- o No: Please explain_____

I certify under penalty of perjury that the above information provided on this form is a true and correct representation. I understand that a deliberate misrepresentation of the facts on this affidavit may result in the termination of this dependent's medical coverage and that the Onondaga County Health Plan has the right to be reimbursed from the Employee for any medical and/or prescription drug claims paid by the Plan during the period the Dependent did not qualify for coverage.

Retiree Signature: _____ Date: _____

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