MSCS Group Health Plan Spousal Verification Form		
○ NEW HIRE ○ QUALIFYING EVENT		
SECTION A: EMPLOYEE INFORMATION		
NAME:	PHONE NUMBER:	
LAST 4 DIGITS OF SSN:	DATE OF BIRTH:	
ADDRESS:		
CITY:	STATE:	ZIP:
EMPLOYEE ID:		

SECTION B: SPOUSE INFORMATION	
SPOUSE NAME:	
SPOUSE LAST 4 DIGITS OF SSN:	DATE OF BIRTH:

SECTION C: STAUS OF EMPLOYMENT
○ RETIRED ○ UNEMPLOYED ○ SELF-EMPLOYED ○ EMPLOYED WITH MSCS ○ EMPLOYED WITH ANOTHER COMPANY
If you selected the employed with another company option, please have your spouse's employer to complete section D. If you selected the other options, please skip section D and submit form directly to MSCS Benefits Office.

SECTION D: SPOUSE EMPLOYMENT INFORMATION *To be completed by spouse's employer only*	
IS THE PERSON NAMED ABOVE AS SPOUSE ELIGIBLE FOR COVERAGE WITH YOUR COMPANY? ○ YES ○ NO	
IF YES, DOES THE EMPLOYEE'S SHARE, EXCEED 50% OF THE TOTAL COST OF PREMIUMS FOR YOUR CHEAPEST INDIVIDUAL COVERAGE? ○ YES ○ NO	
EMPLOYER NAME:	
EMPLOYER ADDRESS:	
EMPLOYER PHONE NUMBER:	
COMPLETED BY NAME (PRINT):	TITLE:
SIGNATURE:	DATE:

Please return completed form to MSCS Benefits Office:

160 S. Hollywood St, Barnes Building, Rm 108, Memphis, TN 38112
Email: benefits@scsk12.org
Fax: 901-416-6463

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