

# PEBTF

## Employer Benefit Verification Form

The Pennsylvania Employees Benefit Trust Fund (PEBTF) provides health benefits to Commonwealth of Pennsylvania employees and retirees. The below-referenced member is enrolled in PEBTF health benefits as a spouse/domestic partner of a commonwealth employee. For employees hired on or after 8/1/03, PEBTF eligibility rules require that the spouse/domestic partner **must** take his or her own employer's health benefit coverage even if he or she has to pay for the coverage or if the employer offers an incentive to decline the coverage. The spouse/domestic partner would have primary coverage through his or her employer's coverage and may remain on PEBTF benefits for secondary coverage.

**To be completed by the PEBTF employee member:  
Please print information below**

Commonwealth employee's name:	
Commonwealth employee number:	
Commonwealth employee's date of birth:	
Spouse/domestic partner's name:	
Spouse/domestic partner's date of birth:	
My spouse/domestic partner is employed.	<input type="checkbox"/> Yes <input type="checkbox"/> No
My spouse/domestic partner works part time.	<input type="checkbox"/> Yes <input type="checkbox"/> No
My spouse/domestic partner works full time.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee's signature:	

**To be completed by an authorized representatives of the spouse's/domestic partner's employer:**

Company name:	
Is health insurance available to the spouse/domestic partner listed above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please indicate the date that the spouse/domestic partner is eligible for benefits.	
Is the named spouse/domestic partner currently enrolled in your company's health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the named spouse/domestic partner waive coverage when insurance was available to them?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please indicate termination date:	

_____	_____
Employer Representative (print name)	Title
_____	_____
Employer Representative Signature	Date
	_____
	Telephone Number

PEBTF, 150 S. 43<sup>rd</sup> Street, Harrisburg, PA 17111