Form S2

DOVER AREA SCHOOL DISTRICT
Verification of Eligibility for Medical Health Coverage Form

To: Employer

(Please complete Health Coverage Verification Form for your employee)

District Employee's Name: _____

Spouse Name:_____

Spouse Employer's Name:_____

Spouse Employer's Phone Number: _____

Spouse Employer's Address:_____

Name of Individual Completing this form:_____

Please complete, sign, date and return this form to the address on the bottom of this form.

1. Is the Spouse noted above (your employee) currently eligible for Health Coverage under your employer plan? YES _____ NO _____ (*If **Yes**, continue to #3) (If **No**, continue to #2)*

2. Why is the Spouse <u>not</u> eligible for your employer Health Coverage? Please provide details.

   _____

   _____

3. Is the Spouse (noted above) currently covered under your employer Health Coverage?
   YES _____ NO _____

I certify that the above information is correct.

Employer Representative _____

Employer Signature _____

Date: _____

Return this form no later than May 5, 2025 to:

Dover Area School District
Human Resources Department
101 Edgeway Road
Dover, PA 17315
Attn: Heather Thomas
Fax: 717-641-7311