Ally Building Solutions Health Benefit Plan

Supplemental Medical Application for Spouse

(To be completed if spouse coverage is elected)

If you would like to enroll or continue to cover your spouse for medical coverage through the Ally Building Solutions Health Benefit Plan, the following information must be completed in order to determine if your spouse meets the eligibility guidelines of the plan.

Please note: Working spouses with access to employer medical coverage are not eligible for coverage, nor are spouses covered under any health insurance policy, including Medicare.

Employee Name:	**Employee SSN or Member ID:**

Spouse Name:	
1) Is your spouse employed?	☐ **No** ☐ **Yes**
If Employed, Provide Employer Name, Address & Telephone Number:	
2) Is your spouse covered under ANY other health insurance plan, including Medicare? ☐ **No** ☐ **Yes**	

ELIGIBILITY DETERMINATION:

1) **If you answered "No" to question #1 and #2 above,** your spouse **IS eligible** for coverage through the Plan and no additional information is needed.
2) **If you answered "Yes" to the spousal employment question (#1)** and your spouse is **not eligible for medical coverage through his/her employment**, your spouse **IS eligible** for coverage through the Plan and no additional information is needed.
3) **If you answered "Yes" to the spousal employment question (#1),** and your spouse **is eligible for medical coverage through their employment**, your spouse is **NOT eligible** for coverage through this Plan.
4) **If you answered "Yes" to question #2 above,** your spouse is **NOT eligible** for coverage through the Plan.

By signing this form I understand that my spouse is only eligible for medical benefits through this Plan if he/she does not have access to employer sponsored medical coverage, if employed or if he/she is NOT covered by another health insurance plan, including Medicare.

I further understand that it is my responsibility to immediately notify Human Resources if any change should occur that would cause my spouse to lose eligibility. If I fail to notify Human Resources within 30 days of this change, I will be responsible for all claims incurred from the date eligibility is lost. In addition, late notification of loss of eligibility of my spouse will void his/her right to elect COBRA continuation coverage.

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Employee Signature **Date**