

# PLEASANT VALLEY SCHOOL DISTRICT SPOUSAL ELIGIBILITY CERTIFICATION

## Verification of Eligibility for Health Coverage Form (BOTTOM SECTION TO BE COMPLETED BY SPOUSE'S EMPLOYER)

Pleasant Valley School District Employee's Name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Employer's Name: \_\_\_\_\_

Spouse's Employer's Phone Number: \_\_\_\_\_

Spouse's Employer's Address: \_\_\_\_\_

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### To be Completed by Spouse's Employer

1. Is the Spouse (noted above) 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 not eligible for your employer Health Coverage? Please provide details, then sign, date and return this form to the address on the bottom of this form.

\_\_\_\_\_

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

*Please complete the chart below for the least expensive single coverage plan.*

| Current Health Insurance Rates for 2026                   |                                                            |                                  |
|-----------------------------------------------------------|------------------------------------------------------------|----------------------------------|
| Employer's total medical premium cost for Single Coverage | Employee's required premium share cost for Single coverage | % employee pays of total premium |
| \$_____/month                                             | \$_____/month                                              | _____%                           |

**I certify that the above information is correct.**

Human Resources or Benefit Contact Name (Printed): \_\_\_\_\_

Human Resources or Benefit Contact Name (Signed): \_\_\_\_\_

Date: \_\_\_\_\_

Sign, Date and Return this form to:  
Pleasant Valley School District  
Attn: Rosemarie Lobe-Waller - Benefits Bookkeeper  
District Office  
2233 Route 115, Suite 100  
Brodheadsville, PA 18322  
Fax: 570-402-1142