INTEGRIS Benefit Verification and Information Release Authorization Form

Section 1: Benefit Verification Information – To be completed by INTEGRIS employee number:___________________

Employee Name:	Spouse Name:	Employee Phone:

Is your spouse employed? Yes ☐ No ☐

If you checked No, please sign and date Section 1 below and return to *INTEGRIS*

*If you checked **Yes**, please continue to the next question.*

Is your spouse employed by INTEGRIS? Yes ☐ No ☐

*If you checked **Yes**, please sign and date Section 1 below and return to INTEGRIS.*

*If you checked **No**, please sign and date Section 1 below. Please have your spouse complete Section 2.*

Failure to fully respond to this letter will result in a $35.00 per pay period surcharge deduction from your pay check for enrolling a dependent Spouse that is eligible for medical coverage provided by their employer.

If you have questions regarding this letter, document requirements, or need assistance on where to obtain requested documentation, contact INTEGRIS Human Resources Customer Service at 405.949.4045.

By signing below, I hereby certify and warrant to INTEGRIS that all information on this form is true, correct and current as of the date signed. I further understand if I knowingly submit false information I may be subject to disciplinary action, up to and including termination of employment and appropriate legal recourse. Furthermore, my signature authorizes INTEGRIS to verify any and all documents provided and may contact any institution or organization to verify the facts as stated herein.

Employee Signature: ______________________________ Date: ______________

Section 2: Information Release Authorization – To be completed by INTEGRIS employee's Spouse.

I authorize the use or disclosure of the requested information for the following purpose: Healthcare eligibility information provided to INTEGRIS will be used solely for determination of my eligibility for coverage under an INTEGRIS plan sponsored by INTEGRIS. This authorization for release of the above information to INTEGRIS will expire following termination of coverage.

I understand that I am signing this authorization voluntarily and that eligibility for coverage under an INTEGRIS plan sponsored by INTEGRIS will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization will be the application of the $35.00 per pay period surcharge for enrolling a spouse that is eligible for medical coverage through their employer.

Spouse Signature: ______________________________ Date: ______________

Section 3: Employer Verification – To be completed by Spouse's employer

Please provide the following information for your employee:

Is the above listed spouse (your employee) eligible to enroll for Major Medical coverage through your company during an open enrollment or qualifying event window? Yes ☐ No ☐

Company Name: ______________________________

HR/Benefits Contact Name: ______________________________

Contact Title: ______________________________

Contact Signature & Date: ______________________________

Contact Phone Number: ______________________________

Submit completed form to INTEGRIS fax at 405.945.4480 or by mailing to 3520 NW 58th St., Ste. A-100, Oklahoma City, OK 73112.
You may also can and email this form to HRCustomerService@integrisok.com