DUQUESNE UNIVERSITY

DUQUESNE UNIVERSITY – LEGAL SPOUSE INSURANCE INQUIRY

Return all required documents to the Benefits Office **within 30 days of the enrollment request.**

Email: trevorsk@duq.edu

Mail: 600 Forbes Avenue, Attn: Benefits Office, Pittsburgh, PA 15282

Employee Name: _____ D Number: _____ Phone Extension: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____

TO BE COMPLETED BY THE ABOVE LISTED LEGAL SPOUSE

I authorize my employer to release this information on my behalf.

Signature of legal spouse: _____ Date: _____

TO BE COMPLETED BY THE ABOVE LISTED LEGAL SPOUSE'S EMPLOYER:

Dear Employer,

Your cooperation is required to assist in the review of your employee's access to insurance coverage.

Please check ONE appropriate answer:

- ☐ We **do not** offer group medical coverage to our employees.
- ☐ We offer group medical coverage and this employee is enrolled.
- ☐ We offer group medical coverage and this employee was eligible but did not enroll.
- ☐ We offer group medical coverage but this is a new employee who will be eligible on ___/___/_____.
- ☐ We offer group medical coverage but this employee is part-time and is not eligible.
- ☐ We offer group medical coverage but this employee is not eligible because *(please explain)*: _____

  _____

My signature is confirmation that the group benefit plan information I have provided above is true and accurate.

Signature of employer representative _____ Date_____/_____/_____

Print representative name _____ Title _____

Print employer name _____ Business Phone (_____) _____

Address _____ City _____ State _____ Zip _____