HILLMAN

2026 SPOUSE ELIGIBILITY FORM

The Spouse Eligibility Form allows eligible Hillman employees to apply for medical coverage for their spouse under the Hillman medical plan. This form must be completed and submitted in its entirety.

- **Section A** must be completed by your spouse.
- **Section B** must be completed and submitted by your spouse's employer.
- Once Section A and B are completed, return the completed form to:
  - Email or Fax: Benefits@hillmangroup.com or Fax to 513.851.2287

Failure to submit the completed form will result in your spouse being *ineligible* for coverage.

Hillman Employee Name: _____ **Hillman Employee ID Number:** _____

Section A (Completed by Spouse)

Your Legal Name: _____

Your Date of Birth: _____

1. Your Employment Status:
   - ☐ Full-time (Employer must complete Section B)
   - ☐ Part-time (Employer must complete Section B)
   - ☐ Self-employed
   - ☐ Unemployed
   - ☐ Retired

2. I am eligible for employer sponsored medical coverage outside of Hillman (excluding Medicare)
   - ☐Yes
   - ☐ No

   2a. If yes, are you currently enrolled in your employer's medical plan?
   - ☐ Yes
   - ☐ No

   2b. If no, did you decline coverage
   - ☐ Yes
   - ☐ No

Attestation

Spouse's Signature: _____ Date: _____

I authorize my employer to release to The Hillman Group the information requested in SECTION B

Hillman Employee Signature: _____ Date: _____

Providing false information will result in disqualification of insurance coverage and potentially disciplinary action

Complete the Employee information section on the back page before submitting to your spouse's employer for completion.

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Employee Information

Hillman Employee Name: _____ **Hillman Employee ID Number:** _____
Employee Name (Spouse): _____ **Employee ID (if applicable):** _____

Please complete the following applicable information on your employee:

Section B
TO BE COMPLETED BY SPOUSE'S EMPLOYER

The Hillman Group Medical Benefit Plan requires verification of spousal medical coverage. If you offer more than one medical plan, include the plan with the lowest premium for employee coverage. We appreciate your time and assistance.

Employer Name: _____

1. Is the spouse currently employed by your company
   ☐ Yes
   ☐ No

2. Is the employee currently covered under your Medical Plan
   ☐ Yes (go to 2a)
   ☐ No (go to 2b)
   ☐ We do not offer Medical Coverage

   2a. If yes, employee coverage start date: _____

   2b. If no, was the employee offered insurance and declined
   ☐ Yes
   ☐ No
   ☐ This employee is not eligible to enroll in Medical Coverage

   Explanation: _____

Plan Details
Employee only premium per pay $_____

Employer contribution to plan per pay $_____

Pay Frequency: _____

Employee pays: _____% of cost Employer pays: _____ % of cost

Benefits Representative Name: _____

Email: _____ **Phone: _____**

Signature: _____

Return the completed form via Email:
Benefits@hillmangroup.com or Fax to 513.851.2287