Affidavit of Spousal Health Care Coverage

Name of Employee: _____Name of Spouse:_____

Important: please ensure this form is <u>fully completed.</u>
Your response, or lack of response, will impact your spouse's health care coverage.

SECTION I: Spouse Employment Information

Is your spouse currently employed?

☐ Yes (sign below, continue to Section II)

☐ Self-employed (sign below, skip Section II)

☐ Part-time - working an average of less than 30 hours per week (sign below, skip Section II)

☐ Not employed / Retired (sign below, skip Section II)

Spouses who are offered or have access to medical coverage through his/her own employer (except for part-time workers) will not be eligible for coverage under the company's medical plan. If your spouse is removed from the company's medical coverage due to the plan's provision, you will receive a letter of coverage which should allow your spouse to be enrolled in his/her employer's plan due to a life event.

I certify under penalty of perjury that the foregoing is true, correct and current. I understand as an employee that willful falsification of information on this Affidavit may lead to disciplinary action, up to and including discharge from employment.

_____ _____

Employee Signature *(required)* Date

SECTION II: Employer Certification of Spouse's Health Benefit Coverage

NOTE: This section must be completed in full by <u>your spouse's employer if they are offered medical coverage</u>

Was the Spouse named above offered medical coverage through your company? ☐ Yes ☐ No

If you offer coverage, does the spouse have to pay 50% or more of the cost for coverage? ☐ Yes ☐ No

Total Monthly Premium: $_____ Monthly Employee Premium/Contribution: $_____

If the spouse is not eligible for coverage yet due to a waiting period, please advise when that waiting period will end?

_____

Name of employer: _____

Name of Representative (Printed): _____Phone: (_____)

Signature of Representative: _____

Representative's Title: _____Date: _____