

SPOUSAL MEDICAL COVERAGE AFFIDAVIT due to your Business Manager by November 18

Employee Name: _____

Spouse Name: _____

If your spouse does not have access to medical insurance through his/her employer, please review the statements below, check the box that applies to your situation, sign the form, and give it to your Business Manager or DAS by November 18.

Please check the statement below that best applies to your situation:

- ☐ My spouse is not employed.
- ☐ My spouse is employed, but their employer does NOT offer any group medical coverage.
- ☐ My spouse is employed but is NOT eligible for the employer's group medical plan due to part-time status (i.e., less than 30 hours per week).
- ☐ My spouse is employed at another participating location.

SPOUSE EMPLOYER INFORMATION

Employer Name: _____

Phone Number: _____

EMPLOYEE CERTIFICATION AND SIGNATURE

I certify that the information provided on this form is true, accurate, and complete to the best of my knowledge. I understand that:

1. My employer reserves the right to verify this information with my spouse's employer at any time.
2. If my spouse's employment or insurance eligibility status changes, I must notify my employer within 30 days of the change.
3. Providing false or misleading information on this form may result in the immediate termination of my spouse's coverage, financial responsibility for paid claims, and disciplinary action up to and including termination of employment.

Employee Signature: _____

Date: _____