Shawnee State University

Spousal Healthcare Affidavit

(Required only if you wish to cover your spouse under SSU Healthcare)

Name of Employee: _____ Employee ID: _____

Name of Spouse: _____

Important: please ensure this form is fully completed.
Your response, or lack of response, will impact the healthcare coverage of your spouse.

If you are a Shawnee State University employee who has selected healthcare coverage for your spouse, you must complete this form. If applicable, your spouse's employer must complete Section II.

SECTION I: Spouse Employment Information

Is your spouse currently employed?

☐Yes, at an employer other than Shawnee State University (continue to Section II)
☐Self-employed (continue to Section III)
☐Not employed / Retired (continue to Section III)

Please note that if your spouse is working full-time and offered employer-sponsored healthcare coverage with in-network options locally (Ohio, Kentucky, and/or West Virginia), they are no longer eligible for coverage under Shawnee State University's healthcare plan, effective January 1, 2019. This loss of eligibility would be considered a "qualifying event" allowing your spouse to enroll in coverage with their employer. The Department of Human Resources can provide documentation of this loss of coverage, if needed.

Please note Shawnee State University reserves the right to request information to verify the information provided on this form. In the event the the information is not accurate, the University has the ability to deny coverage under Shawnee State University's healthcare plan.

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

NOTE: this section must be completed in full by <u>your spouse's employer</u>.

1. Is the spouse named above full-time and eligible for employer-sponsored healthcare coverage through your company? ☐YES ☐NO
2. If you answered no to the previous question, will he/she become eligible at a later date? ☐YES ☐NO
   a. If yes, please provide the date they will become eligible for coverage:_____

Name of employer: _____

Address of employer: _____

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

Signature of Representative: _____

Title: _____ Date: _____

SECTION III: Acknowledgement – must be signed by above-named Shawnee State University Employee

I certify 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. I further acknowledge that it is my responsibility to notify the the Department of Human Resources if, at any future date, the information provided above changes.

_____ _____
Employee Signature (required) Date

Once complete, this form must be submitted to Human Resources for processing.