



Spouse/Domestic Partner Working Affidavit

Benefit Period: November 1, 2022 to October 31, 2023

Employee Name: _____ Employee ID Number: _____

Please print

If your Spouse/Domestic Partner is eligible for group health insurance coverage through his/her employer's plan, he/she must participate in that group coverage and is not eligible for coverage under the [[CLIENT NAME]] group health insurance plan.

Spouse/Domestic Partner's Name: _____

Is your Spouse/Domestic Partner employed?

- Yes - Complete the remainder of this form
- No - Sign and date the bottom of this form
(proof may be requested - e.g.: unemployment statement, SSI payments, state assistance, etc.)

Is your Spouse/Domestic Partner offered health coverage through his/her employer?

- Yes No

Spouse/Domestic Partner Employer Information:

Employer Name: _____

HR/Benefits Contact & Phone Number: _____

If your Spouse/Domestic Partner is currently enrolled in his/her employer's medical plan, please provide a copy of their insurance card and attach to this form.

If your Spouse/Domestic Partner is **NOT** enrolled in his/her employer's medical plan, please choose from the following:

- My Spouse/Domestic Partner will enroll during his/her employer's open enrollment period (provide date):

- My Spouse/Domestic Partner is a newly hired employee and not eligible for coverage until (provide date):

- My Spouse/Domestic Partner is employed part time and does not qualify for benefits under his/her employer's plan
- My Spouse/Domestic Partner is self employed - proof may be requested
- My Spouse/Domestic Partner is retired

Attestation:

I certify that the answers I have provided on this form are true and accurate. I understand that a person may be committing insurance fraud if he/she submits a form containing false information or deceptive statements. I further understand that if it's discovered that I made false or deceptive statements on this form, I will be subject to disciplinary action up to and including termination of employment.

Employee's Signature

Date

Employee's Spouse/Domestic Partner's Signature

Date

This Enrollment Form template is presented for illustrative purposes. Please consult with your legal and compliance teams to ensure that all information is accurate before sharing with employees.