SPOUSAL HEALTHCARE ELIGIBILITY AFFIDAVIT

Employee Name:_____Last 6 of SSN:_____Name of Spouse: _____

NOTE: If your spouse is employed and their employer offers ACA eligible Group Medical coverage, they **ARE NOT** eligible for Medical coverage under Rutherford County's Medical Plan; regardless of participation in their employer's medical plan.

SECTION 1: SPOUSAL EMPLOYMENT VERIFICAITON INFORMATION

#1_____My Spouse is Unemployed OR Retired OR Employed by Rutherford County.

If unemployed or retired, please provide the last date of employment:_____

Proceed to section 3

#2_____My Spouse is employed but does not have medical coverage through their employer: (select one below)

- My spouse's employer does not offer medical/health insurance
- My spouse receives cash or other incentives instead of participating in the medical/health plan offered by his/her employer
- My spouse will be eligible for coverage after Open Enrollment. Coverage will begin on_____.
- My spouse is currently in a waiting period. Coverage will begin on_____.
- My spouse is not classified as benefit-eligible with his/her employer.

If your spouse if self-employed, please provide the Company Name, Address and Phone Number: _____

SECTION 2: EMPLOYER VERIFICAITON

This section must be completed by the spouse's employer if "#2" is checked above

I hereby certify that the spouse listed on this form is an employee below and the information supplied in response to #2 is accurate and complete to the best of my knowledge.

Employer Name:_____Employer Phone:_____

Employer Address:_____

Authorized Representative:_____Title:_____

Authorized Representative Signature:_____Date: _____

SECTION 3: EMPLOYEE/ SPOUSE CERTIFICAITON

By Signing below, I represent and warrant that all information provided is accurate, current and complete to the best of my knowledge. I understand that any misrepresentation in the information I have provided above will permit Rutherford County to terminate spouse coverage and seek any other legal remedies available including possible prosecution for insurance fraud. Falsification of information regarding the spouse's available coverage will result in at minimum, loss of coverage for my spouse and may result in disciplinary action against the employee up to and including termination.

I also understand that is the status of medical coverage for my spouse changes, as the employee of Rutherford County, it is my responsibility to notify the Rutherford County Risk Management Department within 30 calendar days of the change with supporting Documentation

*Employee Signature:_____ Date: _____

*Spouse Signature:_____ Date: _____