



SPOUSAL HEALTHCARE ELIGIBILITY AFFIDAVIT

Employee Name: _____ Last 6 of SSN: _____

Spouse Name: _____ Spouse Date of Birth: _____

NOTE: If your spouse is employed and their employer offers medical coverage compliant with ACA regulations, they ARE NOT eligible for medical coverage under Rutherford County Government's medical plan, regardless of participation in their employer's medical plan.

SECTION 1: SPOUSAL EMPLOYMENT VERIFICATION INFORMATION

#1 _____ My spouse is unemployed, retired, or employed by Rutherford County Government (NOT Rutherford County Schools).

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 or coverage offered does not meet ACA regulations.

____ My spouse receives cash or other incentives instead of participating in the medical/health plan offered by their 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 their employer.

If your spouse is self-employed, please provide the company name, address and phone number: _____

SECTION 2: EMPLOYER VERIFICATION

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 CERTIFICATION

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 the spouse and may result in disciplinary action against the employee up to and including termination.

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

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____