Spousal Healthcare Eligibility Affidavit

Employee Name _____ Employee ID _____

Spouse Name _____ Last four of SSN (Spouse) _____

School District _____

Section A: Must complete to enroll your spouse in Group Health Plan Coverage.

Your Spouse is:

#1 ☐ Not employed or is Retired

#2 ☐ An employee of one of the Municipal School Districts or Cities listed below: (Please check one)

Arlington Community Schools ☐ Bartlett City Schools ☐

Collierville Schools ☐ Lakeland School System ☐

Millington Municipal Schools ☐ City of Bartlett ☐

Town of Collierville ☐ City of Lakeland ☐

#3 ☐ *Employed or Self-Employed ***WITHOUT*** access to coverage from his/her employer **(MUST COMPLETE SECTION B)**

#4 ☐ *Employed ***WITH*** access to coverage from his/her employer but employer pays less than 50% of the cost **(MUST COMPLETE SECTION B)**

NOTE: ***If none of the above applies then he or she is not eligible for the Group Health Plan. (He or she is eligible for other benefits such as dental, vision, life.)***

I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit my employer to terminate my spouse's coverage and seek any other legal remedies available including possible prosecution for insurance fraud. If applicable, I authorize the release of the health care plan coverage information requested below and authorize its use in accepting the application for the Group Health Plan coverage.

Employee Signature _____ Date _____

Spouse Signature _____ Date _____

Section B: Must be completed by spouse's employer or spouse if self-employed

Is the person named above as Spouse *eligible* for coverage with your company?

YES ☐ NO ☐

If yes, does the employee's share, **exceed 50%** of the total cost of premiums for your cheapest individual coverage?

YES ☐ NO ☐

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

Authorized Employer Name: _____ Title: _____

Authorized Employer Signature _____ Date: _____

Please return completed document to the Employee Benefits office

Email: benefits@bartlettschools.org, Fax: (901)202-0854