Spousal Healthcare Eligibility Affidavit

Gold Medical Plan Only

Employee Name:			**Rocket #**
Spouse Name:			**Spouse Date of Birth**: ____/____/_____
Spouse is: (check one)	☐ Employed other than UToledo	☐ Unemployed/Self-Employed	☐ Retired/Disabled

EMPLOYEE: This form must be completed if you wish to elect UToledo health insurance for your spouse. Please complete sections A & B. If your spouse is employed, their employer MUST complete section C.

Section A :(*place an X in the box to the left of the coverage type selected*)

	Primary Coverage	Spouse is employed, disabled, self-employed or retired, or employed and no coverage is offered. If spouse is employed other than UToledo and makes less than $25,000 per year AND the cost of employer-offered health insurance is greater than $75 per month.
	Secondary Coverage	Spouse is employed other than UToledo and makes greater than $25,000 per year, they MUST elect their employer-offered health insurance as primary coverage. UToledo health insurance would act as secondary coverage with the completion of this form.

Section B: (please read and sign below**)** I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit UToledo to terminate the spouse's coverage and any other legal remedies available including possible prosecution for insurance fraud. **Employee Signature**	**Date**
I authorize the release of the health care plan coverage information requested below and authorize its use in accepting the application for UToledo health benefit coverage. **Spouse Signature**	**Date**

Section C: Eligibility for Other Benefit Coverage- **to be completed by spouse's employer**

Place a check in the appropriate column to the left.

Yes	No	
		The person named as spouse above is eligible for medical coverage. **If no, STOP and sign/date below. No other information is needed**.
		The person named as spouse above makes greater than $25,000 per year.
		The cost to the spouse above for single coverage in the medical plan is less than $75 **per month**
		The person named as spouse above has elected medical coverage. If yes, complete info below: **Insurance Company Name**_____ **Group # _____Policy #**_____
		The person named as spouse above has declined/waived medical coverage. If yes, enter date below. **Date coverage was declined or waived:**

Employer Name	
Employer Address	
Employer Phone #	
Authorized Employer Signature	**Date:**
Title:	