SPOUSAL HEALTHCARE ELIGIBILITY AFFIDAVIT

An Adrian College employee's spouse, who works at an employer other than Adrian College, and is eligible for a health insurance benefit at that employer, is required to elect that employer's health insurance benefit as his/her primary coverage. It is the responsibility of the Adrian College employee to inform the Office of Human Resources within 30 days of any changes to his/her spouse's employment which would affect the spouse's health insurance coverage eligibility.

Who must complete this form?
If you are an Adrian College employee who wishes to select the College's health insurance for your spouse, you must complete this form and return it during the open enrollment election period; or within 30 days of electing health insurance due to new hire or qualifying life event election.

This form must be completed by the following due dates in order to remain eligible to receive discretionary contributions to your Health Savings Account (if enrolled in eligible coverage):

Due Date for 2024-2025 Open Enrollment = June 21, 2024
Due Date for New Hire or Qualifying Life Event Election = Within 30 Days

If you are not married or do not wish to cover your spouse, then you do not need to complete or return this form.

Instructions for Form Completion:

1. Employee **must** complete Section A of this form.
2. If your spouse is employed, he/she and their employer **must** complete Section B on page two of this form.
    a. Note: If a spouse has access to health insurance through their employer, they **must** enroll in that plan as primary for a minimum of single coverage as soon as permissible. The spouse can stay on Adrian College's plan as secondary.
    b. If a spouse would be responsible for 100% of their health care cost, they do **not** need to enroll in their employer's health care program.
3. After all applicable sections have been completed, return the form to Human Resources.

Section A-Spouse Information

Employee Name _____

Spouse's Name _____

My spouse is:
(Please select one)

___ Employed full-time ___ Employed at Adrian College ___ Retired ___ Unemployed
___ Self-employed ___ Employed part time (no insurance) ___ Disabled

I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit Adrian College to terminate my spouse's coverage and seek any other legal remedies available including possible prosecution for insurance fraud.

Employee Signature _____ Date _____

Section B-Eligibility for Other Benefit Coverage (To be completed by spouse and spouse's employer)

To be completed by Spouse:

I authorize the release of the health care plan coverage information requested below.

Spouse's Name _____ Date _____

Spouse's Signature _____ Date _____

To be completed by Spouse's Employer:

Employer Name _____

Employer Address _____

Employer Phone # _____

Name of Employer Representative: _____

1. Is the person named as spouse above eligible for medical coverage?

☐ **NO** If no, - **Please sign and date below and return to the employee.**

☐ **YES** If yes, what percentage is the employee's contribution to their medical coverage? _____
Please continue to question 2.

2. Has the person named as spouse above elected the coverage for which he or she is eligible?

☐ **NO** If no, date coverage was waived or cancelled. _____
Date of next open enrollment: _____
Coverage to be effective: _____

☐ **YES** If yes, coverage level _____ Single _____ Two Person _____ Family
Is coverage high-deductible (per IRS guidelines): _____ YES _____ NO
Coverage effective _____
Insurance Company _____
Group # _____ Policy # _____

Authorized Employer Signature _____

Title _____ Date _____

3. Please return this form to the employee.

Completed form must be submitted to: **Adrian College Human Resources Office**
email to acurtis@adrian.edu, or
Fax @ 517-264-3180.

If you have questions please contact Amber Curtis at (517) 264-3870 or acurtis@adrian.edu.