Affidavit of Spouse and/or Dependent Children Eligibility

This form is to be completed initially, and annually prior to open enrollment, if you are covering your spouse/dependent children on the Archdiocese of Cincinnati Healthcare Plan. **If you do not return this form to your Parish/School/Location administrator during open enrollment and are requesting coverage for your spouse and/or dependent children, your spouse and/or dependent children will not be enrolled in the Archdiocese of Cincinnati Healthcare Plan and your next opportunity to cover your spouse and/or dependent children will be the next open enrollment period**.

It is your responsibility to advise your Business Manager/Location Administrator immediately, and not later than 30 days after, any change in eligibility, if your spouse and/or dependent children become eligible to participate in another employer's group health plan (including any retiree coverage provided by your spouse's former employer). Upon your spouse and/or dependent children becoming eligible in another employer's group health plan, you may either drop the Archdiocese of Cincinnati Healthcare Plan for your spouse and/or dependent children (and yourself if you wish) or continue to cover your spouse and/or dependent children under the Healthcare Plan and pay 100% of the cost of the spouse or dependent child's coverage. Coverage provided by your dependent child's employer is not considered other employer group health plan coverage that triggers the surcharge. The surcharge will only apply if the dependent children are eligible for coverage as a dependent child under your spouse or another parent's employer's group health plan.

For purposes of applying the surcharge, the following types of coverage are considered other employer group health plan coverage:

- Any type of major medical coverage, including an HMO, PPO, network only or high-deductible health plan (with or without an HSA), whether the coverage is provided as active employee or as a retiree;
- Health Reimbursement Arrangement (HRA); or
- Medical Reimbursement Arrangement (MERP).

The following types of health care coverage are NOT considered employer group health plan coverage for purposes of the surcharge:

- Medicare, Medicaid or Tricare coverage;
- Individual insurance policies purchased on a governmental exchange;
- Stand-alone dental or vision coverage;
- Health flexible spending account (FSA);
- Employee assistance program (EAP); or
- Drug discount card.
- Any type of health or medical plan coverage provided by your dependent child's employer

If you are unsure of whether the type of coverage offered by your spouse's employer (or your dependent children's other parent) is other group health plan coverage, please contact your business manager. If you submit false information or fail to timely advise the Archdiocese of Cincinnati Healthcare Plan of a change in your spouse or dependent children's eligibility for other employer group health plan coverage, your spouse/dependent children's coverage **will be terminated retroactively** to the date such other coverage became available to your spouse/dependent children. If the Archdiocese of Cincinnati Healthcare Plan provided benefits to which your spouse/dependent children were not entitled during that period, you will be personally liable to the Archdiocese of Cincinnati Healthcare Plan for reimbursement of benefits and expenses, including attorneys' fees and costs, incurred by the Archdiocese of Cincinnati. Any amount to be reimbursed by you may be deducted from the benefits to which you would otherwise be entitled.

Employee Section - PLEASE COMPLETE ALL INFORMATION REQUESTED IN THIS SECTION

Employee Full Name____ **Location Name:**_________________________

Home Address: ____**Phone:** _________________________

Email: __________________________________

Dependent Child(ren) Name (s):____

Dependent Child(ren): Do they have access to employer's group health coverage through other parent? ❒*Yes* ❒*No*

Spouse Full Name:____

Spouse is: ❒ Employed *with* access to employer's group health coverage

Can dependents be covered under spouse's employer's group health coverage? ❒*Yes* ❒*No*

❒ Employed *without* access to employer's group health coverage

❒ Self Employed

❒ Not Employed

❒ Retired *with* access to former employer's group health coverage

❒ Retired without access to former employer's group health coverage

If you indicated that your spouse is employed, with or without access to employer group health coverage, proceed with completion of this form by your spouse's employer, then sign and date at the bottom. If you indicated that your spouse is self-employed, unemployed or retired, proceed to the employee's certification and signature section.

Spouse's Employer Information - TO BE COMPLETED BY THE EMPLOYER OF THE SPOUSE

Company Name: ____

Company Address: ____

1. **Do you offer a group health plan to your employees?** Yes ☐ No ☐
2. **If so, is the spouse listed above eligible for coverage in your plan?** Yes ☐ No ☐
3. **If so, is the spouse listed above eligible to cover his/her dependent children in your plan?** Yes ☐ No ☐
4. **If the employee is NOT eligible for your company's health plan, please explain why. If eligibility is pending, please provide date that the spouse will become eligible for your plan.**

____

Spouse's Employer Certification and Signature

I hereby certify that the information provided in the above employer section is accurate and truthful.

Print Name/Title: ____

Spouse's Employer Signature:______________________________ **Date:** ____________

Employee's Certification and Signature

❒ **I hereby certify that I am legally married to the above named spouse and that the information provided on this affidavit of spouse eligibility is accurate and truthful.**

❒ **I hereby certify that the information provided on this affidavit of dependent child(ren) eligibility is accurate and truthful.**

Employee Signature:______________________________ **Date:** ____________

Return completed form to your Parish/School/Location Administrator. Thank you!

THIS SECTION IS FOR BUSINESS MANAGER/LOCATION ADMINISTRATOR USE ONLY.

Received By:______________ Received Date:__________ Processed in BAS:________

Revised: 4/20/2017