

Spousal Medical Coverage Affidavit



Last Name: _____

First Name, M.I.: _____

This Affidavit must be completed by any employee wishing to enroll a spouse in the Archer & Greiner P.C. medical/prescription drug plan.

In accordance with the firm's health plan, effective May 1, 2016, an employee whose spouse is eligible for health insurance through his/her own employer is no longer eligible for coverage through the Archer & Greiner P.C. medical/prescription drug plan. Spouses who are not employed or not eligible for health insurance through his/her own current employer are not affected by this change. This does not affect dependent children coverage. Please contact the Benefits Administrator if you have any questions.

In order to enroll your spouse in the Archer & Greiner P.C. medical/prescription drug plan you must indicate your spouse's eligibility below, complete and sign this Affidavit, and then return it with your health insurance enrollment materials.

Please read and check one choice in order to indicate your spouse's eligibility under the Archer & Greiner P.C. medical/prescription drug plan:

_____ My spouse is unemployed and is eligible to be covered under the Archer & Greiner P.C. medical/prescription drug plan.

_____ My spouse is employed but his/her employer does not offer or provide access to medical coverage and is therefore eligible to be covered under the Archer & Greiner P.C. medical/prescription drug plan.

Name of Spouse's Employer: _____

Address of Spouse's Employer: _____

Employer Phone Number: _____

I do hereby attest that the above information is true and correct to the best of my knowledge. I understand Archer & Greiner P.C. reserves the right to request supporting documentation and any proof as it, in its sole discretion, deems necessary in order to verify the representations I have made in this Affidavit. The Firm reserves the right to audit the information provided by the employee supporting the access of non-employee working spouses to the Archer & Greiner medical plan. I also understand that if my spouse's group medical insurance status changes, it is my responsibility to notify the Benefits department within 30 days of such change.

I further acknowledge that if my spouse is covered under the Archer & Greiner PC medical/prescription drug plan and it is later determined that my spouse was eligible for other group medical coverage through his/her employer, I may be required to repay the firm's premium equivalent costs for my spousal coverage from the date the coverage under my spouse's employer medical plan became available to my spouse. I further understand that knowingly falsifying this form or making any false statement or representation in connection with this form may result in retroactive payroll contribution adjustments and/or disciplinary action up to and including termination of employment.

PRINT EMPLOYEE NAME: _____

EMPLOYEE SIGNATURE: _____

DATE: _____

To be completed by the Benefits Department	
_____	_____
Date Received	Initials