ALLEGHENY COLLEGE

HUMAN RESOURCES

Affidavit for Spousal Coverage

Overview:

If your spouse is eligible to enroll in their employer-sponsored health plan they are **ineligible** to enroll in the Allegheny College medical plan. Please read the information below and select the correct statement that applies to you and your spouse. ***THIS FORM MUST BE COMPLETED BY ALL EMPLOYEES WHO ARE ENROLLING THEIR SPOUSE IN ALLEGHENY COLLEGE'S MEDICAL PLAN***

Certification:

Employee Name _____ Benefit Year_____

I certified that my spouse, _____, is **not eligible to enroll in his / her employer-sponsored health plan due to (circle one of the two options below):**

- **Option 1**: Employer does not offer health coverage
- **Option 2:** Spouse not employed

*If your spouse's employer does not offer coverage **(Option 1)**, please complete the below:*

Employer's Name: _____

Employer's Address: _____

Contact Name: _____

Contact's Telephone Number: _____

I, _____, give permission for Allegheny College to verify the above information is accurate and contact my spouse's employer.

I understand that it is my responsibility to notify my employer within 31 days of my spouse losing eligibility under their employer's medical plan for me to enroll them in Allegheny College's medical plan as a dependent under my plan; or

I also understand my employer may ask at any time if the status of my spouse's eligibility for his/her employer's plan has changed.

I certify that the foregoing is true and accurate to the best of my knowledge.

Employee Signature _____ *Date* _____

PLEASE COMPLETE FORM AND SEND:
Email: hr@allegheny.edu
Mail: Box 4