

# AFFIDAVIT OF SPOUSE HEALTH CARE COVERAGE



PLEASE ENSURE THIS FORM IS FULLY COMPLETED. YOUR RESPONSE, OR LACK OF RESPONSE, WILL IMPACT YOUR SPOUSE'S HEALTH CARE COVERAGE.

PARTICIPANT NAME	PARTICIPANT SSN	NAME OF SPOUSE

Effective January 1, 2017, all spouses enrolled in the City of Shreveport Medical Plan who are eligible for medical coverage under the group health plan of another employer will be subject to a **monthly premium surcharge**. If your spouse does not have other medical coverage available, your spouse will be allowed to enroll in the plan at the regular applicable premium rate.

You must, however, complete the information listed below and return this form to Benefits to certify that other medical coverage is not available to your spouse. If there is a change in your spouse's coverage, you must notify the City of Shreveport within 30 days of the change.

## Section 1: Spouse Employment Information

**NOTE: This section must be completed by the City of Shreveport employee or retiree.**

Is your spouse currently employed? (Please check only one box.)

- |  |  |
|--|--|
| <input type="checkbox"/> Yes employed and offered group coverage (Surcharge)         | (Sign below – Continue to Section II)  |
| <input type="checkbox"/> Self-employed and offered group coverage (Surcharge)        | (Sign below – Section II not required) |
| <input type="checkbox"/> Self-employed and not offered group coverage (No Surcharge) | (Sign below – Section II not required) |
| <input type="checkbox"/> Yes employed and not offered group coverage (No Surcharge)  | (Sign below – Section II not required) |
| <input type="checkbox"/> Not employed/Retired (No Surcharge)                         | (Sign below – Section II not required) |
| <input type="checkbox"/> Also an employee of the City of Shreveport (No Surcharge)   | (Sign below – Section II not required) |

I certify, under penalty of perjury, that the foregoing and following is true, correct and current. I understand as an employee or retiree of the City of Shreveport, willful falsification of information on this affidavit may lead to disciplinary action.

PARTICIPANT SIGNATURE	DATE

## Section 2: Employer Certification of Spouse Health Benefit Coverage

Is the spouse named above eligible for group health care coverage through his or her employer?

CIRCLE ONE	COMPANY NAME (SPOUSE'S EMPLOYER)
Yes No	