MEBC HEALTHCARE PLAN SPOUSAL AFFIDAVIT

(ONLY REQUIRED IF YOU ARE INSURING A SPOUSE IN AN MEBC PARTICIPATING COUNTY)

MEBC EMPLOYEE'S NAME	EMPLOYEE UNIQUE IDENFIFIER	EMPLOYEE DOB	EE GENDER

SPOUSE'S NAME	SPOUSE IDENTIFIER	SPOUSE DOB	SP GENDER

PART #1

DOES YOUR SPOUSE WORK? ☐ YES *(CONTINUE TO PART 2)*

☐ NO *(SKIP TO PART 3)*

PART #2

NAME OF SPOUSE'S EMPLOYER _____

ADDRESS OF SPOUSE'S EMPLOYER _____

PHONE # OF SPOUSE'S EMPLOYER _____

MUST BE COMPLETED BY YOUR SPOUSE'S EMPLOYER:

DO YOU OFFER A HEALTHCARE PLAN? ☐ YES ☐ NO

IS THIS INDIVIDUAL ELIGIBLE TO PARTICIPATE? ☐ YES ☐ NO

IS THIS INDIVIDUAL CURRENTLY ENROLLED? ☐ YES ☐ NO

SIGNATURE OF EMPLOYER RESPONDENT _____

PHONE NUMBER OF EMPLOYER _____

SIGNATURE OF EMPLOYEE (SPOUSE) _____

PART #3

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

Signature of Employee (REQUIRED): _____ **Date**: _____

MAIL IN ENCLOSED ENVELOPE OR FAX TO (216) 373-3476 WITH APPROPRIATE PAPERWORK