Plan Year 2011

The University of Toledo
Spousal/Domestic Partner Healthcare Eligibility Affidavit

Employee Name: _____ **R# or SS#:** _____

Employee Campus: ☐ Main Campus ☐ Health Science Campus

Spouse/Domestic Partner Name: _____

A. Who must complete this form?

If you are a University of Toledo employee who wishes to select UT's health insurance coverage for your spouse/domestic partner, you **MUST** complete sections **A** and **B** of this form. If your spouse/domestic partner is employed, their employer **MUST** complete section **C**. The spousal/domestic partner criteria is as follows:

If a spouse/domestic partner has accessibility to health insurance through their employer, they must enroll in that plan as primary for a minimum of single coverage and may stay on the UT plan as secondary. If the spouse/domestic partner makes $25,000 or less per year and the employee contribution for health insurance through their employer would cost them more than $75/month for a single plan, they may be carried on the UT plan as primary.

B. Spouse/Domestic Partner is:

☐ **employed @ UT-HSC** ☐ **employed @ UT-MC**
☐ **employed full time** ☐ **employed part time** ☐ **unemployed**
☐ **self employed** ☐ **retired** ☐ **disabled**

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

Employee Signature _____ Date _____

I authorize the release of the health care plan coverage information requested below and authorize its use in accepting the application for UT health benefit coverage.

Spouse/Domestic Partner Signature _____ Date _____

C. Eligibility for Other Benefit Coverage

To be completed by spouse/domestic partner's employer:

1. Is the person named as spouse/domestic partner above eligible for medical coverage?
   - **NO** If no, **STOP**. You do not need to complete the rest of this form. Please sign, date and return to the employee.
   - **YES** If yes, continue to question 2.
2. Is the person named as spouse/domestic partner above making $25,000/year or less?
   - **NO** If no, continue to question 4.
   - **YES** If yes, continue to question 3.
3. Do you offer the person named as spouse/domestic partner a health plan in which their employee contribution would cost them more than $75/month for a single plan?
   - **NO** If no, continue to question 4.
   - **YES** If yes, **STOP**. You do not need to complete the rest of this form. Please sign, date and return to the employee.
4. Has the person named as spouse/domestic partner above taken the coverage for which he or she is eligible?
   - **NO** If no, date coverage was waived or cancelled _____.
   - **YES** If yes, ____ Single or ____ Family Coverage effective _____
     Insurance Company _____
     Group # _____ Policy #_____

Employer Name _____

Employer Address _____

Employer Phone Number _____

Authorized Employer Signature _____

Title _____ Date _____