Affidavit of Spousal Health Care Coverage

An Employee's spouse who has access to health care that provides minimum value (as defined by the Affordable Care Act)* through their own employer is not eligible for enrollment in the Bradley University Medical Plan, regardless of the cost to the spouse and regardless of whether the spouse has been offered an incentive to decline such coverage. The Bradley University Medical Plan does not provide secondary coverage on a spouse who has primary coverage. This allows the University to maintain affordable coverage for its employees, spouses who have no other health care choice, and dependent children. Please note that this only applies to Medical coverage; no other benefits are affected by this policy.

Employees who wish to cover their eligible spouse on the Bradley University Medical Plan must complete the Spousal Affidavit below. This affidavit must be signed and returned to Human Resources; otherwise, your spouse will be considered ineligible and will not be enrolled on the Bradley University Medical Plan.

TO BE COMPLETED BY BRADLEY UNIVERSITY EMPLOYEE

Bradley University Employee Name **(please print)**: _____

Spouse's Name **(please print)**: _____Spouse's DOB: _____

TO BE COMPLETED BY SPOUSE'S EMPLOYER

Company Name: _____

Company Address: _____

☐ My employee **is** eligible for medical coverage through our organization.

☐ My employee **is not** eligible for medical coverage through our organization.

Reason not eligible: _____

Employer Representative Printed Name & Title: _____

Signature: _____

Phone Number: _____

If your spouse is not employed, please continue to next page

BRADLEY University

EMPLOYEE DECLARATION

Spouse's Name **(please print)**: _____

Spouse's DOB: _____

My spouse is (check one):

- Retired _____
- Self-Employed _____ (*Note: A spouse is <u>not</u> self-employed if they receive a W-2)*
- Unemployed _____

<u>I attest that all information above is true and correct to the best of my knowledge.</u>

- *I understand that falsifying any information contained herein will lead to disciplinary action, up to and including termination of employment.*
- *I understand that if my spouse's employer offers group medical coverage and my spouse is eligible for that coverage, my spouse must enroll in his/her employer's plan regardless of any cost to my spouse or incentive to decline.*
- *I understand that if my spouse is eligible for but does not enroll in his/her employer's medical plan, they will be ineligible for coverage as my dependent under the Bradley University Health Plan.*
- *I understand that my spouse's group medical plan from his/her employer is their primary insurance plan and that the Bradley University Medical Plan does not offer secondary spouse coverage.*
- *I understand that I must inform Bradley University of any changes in employment status of any dependents which may affect their eligibility under the plan, and that my failure to do so may result in the loss of coverage and repayment of any amounts paid on their behalf. If my spouse's employment &/or eligibility for medical care coverage changes, I will notify Bradley University Human Resources immediately. I also understand that I may be required to provide further documentation in the event of a dependent eligibility audit.*

SIGN & DATE

Bradley University Employee Signature (required) _____

Date: _____