



# Main Campus Spousal/Domestic Partner Healthcare Eligibility Affidavit

Employee Name \_\_\_\_\_ SS# \_\_\_\_\_  
(Please Print)

Spouse/Domestic Partner Name \_\_\_\_\_  
(Please Print)

**A. Who must complete this form?**

If you are a Main Campus (UT-MC) employee who wishes to select UT-MC's health insurance coverage for your spouse/domestic partner, you **MUST** complete sections **A** and **B** of this form, your spouse/domestic partner's 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 annually and health insurance thru their employer would cost them more than \$75/month for a single plan/employee contribution, they may be carried on the UT plan as primary.

- B. Spouse/domestic partner is:**
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> employed full time | <input type="checkbox"/> employed @ UT-HSC  | <input type="checkbox"/> employed @ UT-MC |
| <input type="checkbox"/> self employed      | <input type="checkbox"/> employed part time | <input type="checkbox"/> unemployed       |
| <input type="checkbox"/> retired            | <input type="checkbox"/> 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-MC 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-MC health benefit coverage.

Spouse Signature \_\_\_\_\_ Date \_\_\_\_\_

**C. Eligibility for Other Benefit Coverage**

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

- 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 address listed below.  
**YES** If yes, continue to question 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.
- Do you offer the person named as spouse/domestic partner a health plan that would cost them more than \$75/month for a single plan/employee contribution?  
**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.
- 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 \_\_\_\_\_