Spousal/Domestic Partner Healthcare Eligibility Affidavit

Silver and Bronze Rocket Plans Only

Employee Name: _____ **Spouse/Domestic Partner Name:** _____

Rocket #: _____ **Please Check:** ☐ **Silver Plan** ☐ **Bronze Plan**

EMPLOYEE

A. This form must be completed:

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

☐ **Primary Coverage:** * Spouse is unemployed, disabled, self-employed or retired, or employed and no coverage is offered.
* If spouse/domestic partner is employed other than UToledo and makes $25,000 or less per year **AND** the employee cost of their employer offered health insurance costs more than $75/month

☐ **Secondary Coverage:** * If spouse/domestic partner is employed other than UToledo and makes more than $25,000/year they **MUST** take their employer offered health insurance as primary coverage. They may elect to be on The University of Toledo's health insurance plan as secondary coverage with the completion of this form.

B. Spouse/Domestic Partner is: ☐ Employed Other than UToledo ☐ Unemployed/Self-employed ☐ Retired/Disabled

C. *I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit UToledo 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 UToledo health benefit coverage.

Spousal/Domestic Partner Signature _____ Date _____

EMPLOYER

D. 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** *** STOP**. You do not need to complete the rest of this form. Please sign, date and return to the employee.
   - ☐ **YES** * Go to next question.
2. Is the person named as spouse/domestic partner above making $25,000/year or less?
   - ☐ **NO**
   - ☐ **YES**
3. Do you offer your employee a health plan in which their employee contribution would cost them more than $75/month for a single plan?
   - ☐ **NO**
   - ☐ **YES**
4. Has the person named as spouse/domestic partner above elected coverage for which they are 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 _____