



SPOUSAL HEALTHCARE ELIGIBILITY AFFIDAVIT

A UToledo employee’s spouse, who works at an employer other than UToledo and is eligible for a medical insurance benefit at that employer, is required to elect that employer’s medical insurance benefit as his/her primary coverage. It is the responsibility of the UToledo employee to inform the Benefits Department within 30 days of any changes to his/her spouse’s employment which would affect the spouse’s medical insurance coverage eligibility.

Who must complete this form?

If you are a UToledo employee who wishes to select the gold medical insurance plan for your spouse, you must complete this form and return it during the open enrollment election period; or within 30 days of electing medical insurance due to new hire or qualifying life event election.

If you are not married or do not wish to cover your spouse, then you do not need to complete or return this form.

-- Instructions for Form Completion:

1. Employee **must** complete Section A of this form.
2. If your spouse is employed, he/she and their employer **must** complete Section B on page two of this form.
 - a. Note: If a spouse has access to medical insurance through their employer, they **must** enroll in that plan as primary for a minimum of single coverage as soon as permissible. The spouse can stay on UToledo’s plan as secondary.
 - b. If a spouse would be responsible for 100% of their medical plan cost, they do **not** need to enroll in their employer’s health care program. For reference, UToledo covers 80% of the medical plan cost for full-time employees, the employee premium is 20%.

Section A-Spouse Information

Employee Name _____

Employee Rocket ID# _____

Spouse’s Name _____

Spouse Date of Birth: _____

My spouse is:

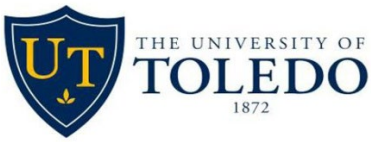
(Please select one)

Employed at UToledo Employed but not at UToledo Retired

Self-employed Unemployed 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 UToledo to terminate my spouse’s coverage and seek any other legal remedies available including possible prosecution for insurance fraud.

Employee Signature _____ Date _____



Section B-Eligibility for Other Benefit Coverage (To be completed by spouse and spouse's employer)

To be completed by Spouse:

I authorize the release of the health care plan coverage information requested below.

Spouse's Name _____ Date _____

Spouse's Signature _____ Date _____

To be completed by Spouse's Employer:

Employer Name _____

Employer Address _____

Employer Phone # _____

Name of Employer Representative: _____

1. Is the person named as spouse above eligible for medical coverage?

NO If no, - **Please sign and date below and return it to the employee.**

YES If yes, what percentage is the employee's contribution to their medical coverage? _____
Please continue to question 2.

2. Has the person named as spouse above elected the coverage for which he or she is eligible?

NO If no, date coverage was waived or cancelled. _____
Date of next open enrollment: _____
Coverage to be effective: _____

YES If yes, coverage level _____ Single _____ Two Person _____ Family
Coverage effective _____
Insurance Company _____
Group # _____ Policy # _____

Authorized Employer Signature _____

Title _____ Date _____

3. Please return this form to the employee.

Completed form must be submitted to benefits@utoledo.edu or can be uploaded in the Document Upload section in your myUT portal under Benefits Information.

If you have questions, please contact UToledo Benefits at 419.530.4747 or benefits@utoledo.edu