



WORKING SPOUSE AFFIDAVIT

WLS Employee Name _____ (please print) Employee ID # _____

Spouse Name _____ (please print) Paramount Subscriber No.: _____

A. Who must complete this form?

If you are a full-time Washington Local employee who is married (as defined and governed by Ohio Law) and elect WLS health coverage for your spouse, you must complete section B of this form. **If your spouse is employed, your spouse's employer must complete section C.** The spouse eligibility requirements are as follows:

- The spouse is employed **and**
- The spouse's employer offers health care coverage **and**
- The spouse is eligible for coverage at 50% or less of the contribution toward a single policy

When all three of these conditions are met, a spouse is required to enroll in at least a single coverage plan with his/her employer.

B. Please check the applicable qualification:

My spouse is:

- | | |
|---|---|
| <input type="checkbox"/> employed full-time | <input type="checkbox"/> self employed |
| <input type="checkbox"/> employed part-time | <input type="checkbox"/> disabled |
| <input type="checkbox"/> unemployed | <input type="checkbox"/> employed by Washington Local Schools |
| <input type="checkbox"/> retired | (complete part B only) |

I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit the Washington Local School District to terminate the spouse's coverage and seek any other legal remedies available including possible prosecution for insurance fraud. I further understand that I must report any changes in my spouse's employment status to Washington Local School Districts Payroll/Insurance secretary.

WLS Employee Signature _____ Date _____

C. Eligibility for Other Benefits Coverage

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

Spouse Signature _____ Date _____

TO BE COMPLETED BY SPOUSE'S EMPLOYER ONLY:

- Is the person named as spouse above employed (full-time or part-time) or retired?
 NO If no, **STOP**. You do not need to complete the rest of this form. Please sign, date and return to the address listed above.
 YES If yes, continue to question 2.
- Does the person named as spouse receive a stipend or other incentive(s) compensation to not enroll in your health care plan?
 NO If no, continue to question 3.
 YES If yes, continue to question 3.
- Do you offer the person named as spouse a single health plan that is 50% or less employee paid?
PLEASE PROVIDE: Employer pays _____% of the premium. Employee pays _____% of the premium.
 NO If no, **STOP**. You do not need to complete the rest of this form. Please sign, date and return to the address listed above.
 YES If yes, please provide percentages and continue to question 4.
- Has the person named as spouse above taken the coverage for which he or she is eligible?
 NO If no, date coverage was waived or cancelled _____
 YES **IF YES, PLEASE PROVIDE COVERAGE INFORMATION:** Single ___ Family ___ Eff. Date _____
Insurance Company _____
Group # _____ Policy # _____

Company Name _____ Date _____

Company Address _____ Phone _____

Authorized Employer Name _____ (please print) Fax _____

Authorized Employer Signature _____ Title _____

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)