SPOUSAL AFFIDAVIT/CERTIFICATION FORM FOR 2024 BENEFITS

Team Member Name _____ Employee ID#_____

Spouse's Name _____

Spouse's Employer _____

Fax completed form to 314-336-5229 or email to St. Luke's Benefits

St. Luke's offers medical coverage to team members, spouses, and family members. St. Luke's preference is that spouses be covered by the spouse's employer as their primary coverage. Therefore**,** St. Luke's has a spousal surcharge when a spouse has other employer-provided coverage available. To determine your appropriate medical premium, please complete the following if a spouse is being added to the St. Luke's health plan for 2024. **Update required yearly.**

Section 1

Is your spouse currently employed? Yes _____ No _____
If YES, complete the next question.
If NO, sign and date below and return the form.

Is your spouse Self-Employed and does **not** have group medical coverage available? Yes _____ No _____
If YES, please sign, date below and return the form.
If NO, please have your spouse's employer complete Section 2.

Is your spouse currently enrolled in their employer's group health plan? Yes _____ No _____
If YES, please sign and date below and return the form.
If NO, please have your spouse's employer complete Section 2.

I certify that the above information is correct. I acknowledge that if it is discovered that my spouse has been offered other medical insurance through their employer, all monies will be recouped for claims paid through the medical insurance plan. I also understand that this form must be completed and sent to the **Benefits Office at** slhstlukesemployeebenefits@stlukes-stl.com to complete enrollment. If the form is not returned, the spousal surcharge will apply.

Signature _____ Date _____

Section 2

Verification of Benefits (To be completed by spouse's employer)
Please provide the following information for your employee who is listed at the top of this page.

Do you maintain a group healthcare plan for your employees? Yes _____ No _____

If yes, is this employee eligible for medical coverage? Yes _____ No _____

_____ _____
Name of Employer Representative Title

_____ _____
Signature of Employer Representative Date

Contact Phone Number _____