SPOUSAL AFFIDAVIT/CERTIFICATION FORM FOR 2021 BENEFITS

Team Member Name _____ Employee ID#_____

Spouse's Name _____

Spouse's Employer _____

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 when they are contributing to the coverage and an offer to select coverage is made. St. Luke's has a spousal surcharge when other coverage is available. For example, coverage through another employer or Medicare eligible. In order to fully determine the appropriate premium, you will need to complete the following if a spouse is being added to the St. Luke's health plan for 2021.

Section 1

Is your spouse currently employed? Yes _____ No _____

If you checked NO, sign and date below and return the form.
If you checked YES, complete the next question.

Is your spouse currently enrolled in their employer's group health plan? Yes _____ No _____

If you checked 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 faxed to the Benefits Office at 314-336-5225 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, do you pay a portion of the premiums? Yes _____ No _____

Is the employee indicated above enrolled in your medical plan? Yes _____ No _____

If not, is there a future date benefits would be effective? _____

_____ _____
Name of Employer Representative Title

_____ _____
Signature of Employer Representative Date

Contact Phone Number _____