SPOUSAL AFFIDAVIT/CERTIFICATION FORM FOR 2022 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. 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 2022.

Section 1

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