ARBenefits

# Affidavit of Spousal Health Care Coverage

**This Affidavit must be completed if you are adding coverage for a Spouse.**

**Please complete the following:**

| | | | |
|---|---|---|---|
| **Employee Name:** | | **Employee SSN:** | |
| **Spouse Name:** | | | |

**To be completed by employee electing to enroll a spouse in coverage. Check all that apply.**

*Any spouse who is offered coverage for Medical Benefits under any other employer-sponsored health plan is NOT eligible to be covered under the Plan.*

**1. Is your spouse currently employed?**

☐ Not Employed

☐ Employed **WITHOUT HEALTH INSURANCE COVERAGE** from his/her employer

☐ Employed **WITH HEALTH INSURANCE COVERAGE** from his/her employer that provides minimum value (as defined by the Affordable Care Act)

**I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I provided above will permit the Plan to terminate my coverage. If applicable, I authorize the release of the health care plan coverage information requested above and authorize its use in accepting the application for the ARBenefits Plan coverage.**

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

**RETURN FORM BY MAIL:** **EMPLOYEE BENEFITS DIVISION**
**P.O. BOX 15610**
**LITTLE ROCK, AR 72231**
**ATTN: ELIGIBILITY**

**RETURN FORM BY FAX:** **501-683-0983**