CARSON TAHOE
HEALTH

DECLARATION OF SPOUSE HEALTH COVERAGE

THIS ATTESTATION **MUST** BE COMPLETED FOR CONSIDERATION TO COVER A SPOUSE IN ELIGIBLE HEALTH COVERAGE.

Employee Name:		Spouse Name:	
Employee ID:			

*A SPOUSE WHO IS ELIGIBLE FOR MEDICAL COVERAGE UNDER AN EMPLOYER-SPONSORED PLAN IS **NOT** CONSIDERED ELIGIBLE TO BE COVERED UNDER CARSON TAHOE HEALTH.*

1. Is your spouse currently employed:
   - ☐ Not Employed
     - Sign and return this form
   - ☐ Employed and Eligible through their employer offered health plan
     - Your spouse is not eligible for CTH Coverage
   - ☐ Employed and **Not** Eligible through employer offered health plan
     - Spouse's employer must complete below required section
   - ☐ Employed and Employer does not offer health insurance plan
     - Spouse's employer must complete below required section

2. I understand that I must provide a copy of my marriage license if electing spousal coverage.
   - ☐ Yes
   - ☐ No

By signing this affidavit, I certify that the information provided above is accurate. I understand that any misrepresentation in the information I provided above may result in disciplinary action up to and including termination of employment. If applicable, I authorize the release of the information noted above, and agree to its use in the application process for Carson Tahoe Health Benefits Plan coverage. I understand that I must supply this affidavit along with any supporting documentation to Human Resources within the election period.

_____ Employee Signature

_____ Date

_____ HR Authorized Signature

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HEALTH

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TO BE COMPLETED BY SPOUSE'S EMPLOYER:

Employee Name:		Spouse Name:	
Employee ID:			

Company Name: _____

Company Address: _____

_____

☐ My employee is eligible for medical coverage through our organization.

☐ My employee is not eligible for medical coverage through our organization.

Reason not eligible: _____

_____

_____

_____

Employer Representative Printed Name & Title: _____

Signature: _____

Phone Number: _____