HENDERSON

City of Henderson Health Plans

Spousal Coverage Affidavit

Instructions: If you intend to include your spouse on the City of Henderson Health Plan, you must complete the information requested, and submit this form to the City of Henderson, Benefits Department, 240 Water Street,

Mail Stop #122, City Hall, 2nd Floor, Henderson, NV 89015

Effective January 1, 2016, the City of Henderson Self-Funded Employee Health Insurance Plan (PPO) require an employee's or retiree's dependent spouse, if covered under the Plan, to enroll in his/her own employer-sponsored program if available.

Before any claims for your spouse can be processed, we need to know your response to the following questions.

Please fill out this questionnaire completely and return to Benefits, MSC 122:

Employee/Retiree Name: _____ Employee I.D.#: _____

1. Spouse Name: _____

   Is your spouse employed? Yes____ No ____

   If No, please sign, date and return this form to Benefits department.

   If Yes, complete the following and continue to the next question.

   Name of spouse's current employer: _____

   Address and Telephone of spouse's current employer:

   Address: _____

   Phone: _____

2. Is your spouse covered by his/her employer's group health insurance plan?

   Yes ____ No ____

   If No, is your spouse eligible for coverage under his/her employer's group health insurance plan?

   Yes ____ No ____

   If No, please sign and date below and provide documentation from the employer indicating why coverage is not available.

   If Yes, spouse must enroll in employer's offered medical coverage if it meets the Affordable Care Act's minimum value and affordability requirements.

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If your spouse's employer provided health plan does not meet the ACA's requirements, please sign below and provide documentation from the employer demonstrating that the employer provided group health insurance plan does not meet the ACA minimum value and affordability requirements.

If your spouse is currently covered under his/her employer provided coverage, please provide the following information on his/her other insurance coverage.

Effective date of medical coverage: _____

Name of insurance company: _____

Address of insurance company: _____

Full names of all dependent(s) covered by spouse's plan: _____

If your spouse recently lost coverage through his/her employer, please provide a copy of the termination letter including the termination date.

**Please be advised that failure to submit this form in a timely manner could result in loss of spousal coverage.

Warning About Fraud
Keeping an ineligible dependent (spouse or child) enrolled is considered fraudulent eligibility, and would require the plan to dis-enroll the ineligible dependent from the plan retroactively to when the dependent became ineligible. In addition, the plan would seek recovery from the employee, any fraudulently paid claims, and may seek other corrective or legal actions as may be appropriate. It should also be noted that the ineligible dependent may not have access to COBRA.

Date: _____

Name (print): _____

Name (signature): _____

Employee ID Number: _____