Employer Verification of Spouse Health Coverage

This form is required if you intend to cover your spouse on your City of Gastonia group health care plan. You must complete Section I of this form. Your spouse's employer, if applicable, must complete Section II. **This form must be completed and returned to the Human Resources Department**.

Please complete this affidavit in its entirety

SECTION I: Questions for You, the Employee

Employee Name: _____ **Employee Number:** _____

Spouse Name: _____ **Telephone Number:** _____

Spouse's Employment Status: ☐ Unemployed ☐ Full-Time (See Section II) ☐ Part-Time (See Section II)

SECTION II: Questions for Employer of Your Spouse

Your Name: _____

Your Title or Position: _____

Name of Company/Organization:

_____

Your direct telephone number: _____

Your direct company email address:

_____

Is this person a benefits-eligible employee?

☐ Yes, eligible and enrolled in health benefits.
☐ Yes, eligible but declined coverage at open enrollment.
☐ Yes, eligible but declined coverage at date of hire.
☐ Yes, eligible but still inside waiting period.
☐ No, not eligible due to hours worked.
☐ No, not eligible for another reason

Reason:_____

_____ _____

Authorized Employer Signature Date

I certify that the statements I made above are complete and accurate as of the form date.

SECTION III: Employee and Spouse Signatures

I certify under penalty of perjury, that the foregoing is true and correct. I understand as an employee that willful falsification of information on this Affidavit may lead to disciplinary action, up to and including discharge from employment.

_____ _____

Employee Signature Date

_____ _____

Spouse Signature Date