SAINT LOUIS UNIVERSITY
EST. 1818

Spousal Healthcare Affidavit

(Required only if you wish to cover your spouse under SLU Healthcare)

Name of Employee: _____ Employee ID: 000

Name of Spouse: _____

Important: please ensure this form is fully completed.
Your response, or lack of response, will impact the medical coverage of your spouse.

If you are a Saint Louis University employee who has selected medical coverage for your spouse, you must complete this form. If applicable, your spouse's employer must complete Section II.

SECTION I: Spouse Employment Information

Is your spouse currently employed?

- ☐Yes, at an employer other than Saint Louis University (continue to Section II)
- ☐Yes, at Saint Louis University (continue to Section III)
- ☐Self-employed (continue to Section III)
- ☐Not employed / Retired (continue to Section III)

Please note that if your spouse's employer provides **qualifying group medical coverage***, which includes preventive care, major medical and prescription drug benefits, and your spouse's employer contributes at least 50 percent of the total premium for single coverage, your spouse must enroll in the spouse's employer's plan. If all the previously stated criteria are met, your spouse will no longer be eligible for coverage under Saint Louis University's medical plan, effective January 1, 2017. This loss of eligibility would be considered a "qualifying event" allowing your spouse to enroll in coverage with the spouse's employer.

Please note Saint Louis University reserves the right to request information to verify the stated criteria are met. In the event the supporting documents do not meet the University's stated criteria, the University has the ability to deny coverage under Saint Louis University's medical plan.

SECTION II: Employer Certification of Spouse's Health Benefit Coverage

NOTE: this section must be completed in full by <u>your spouse's employer</u>.

1. Is the spouse named above eligible for **qualifying group medical coverage*** through your company? ☐YES ☐NO
2. If you answered no to the previous question, will he/she become eligible at a later date? ☐YES ☐NO
   a. If yes, please provide the date they will become eligible for coverage:_____

Name of employer: _____

Address of employer: _____

Name of Representative (Printed): _____ Phone: ( ) _____

Signature of Representative: _____

Title: _____ Date: _____

SECTION III: Acknowledgement – must be signed by above-named Saint Louis University Employee

I certify that the foregoing is true, correct and current. I understand as an employee that willful falsification of information on this Affidavit may lead to disciplinary action. I further acknowledge that it is my responsibility to notify the SLU Benefits Office if, at any future date, the information provided above changes.

_____ _____
Employee Signature (required) Date

Please return to the Benefits Office, located in the Wool Center at 3545 Lindell Blvd, Saint Louis, MO 63103, fax to 314-977-1785, or scan and email to benefits@slu.edu. Please call 314-977-2595 should there be any questions.