UNIVERSITY OF THE CUMBERLANDS EMPLOYEE HEALTH BENEFIT PLAN

WORKING SPOUSE AFFIDAVIT

SECTION 1: EMPLOYEE INFORMATION

_____ _____

NAME UC EMPLOYEE ID NUMBER

SECTION 2: SPOUSE INFORMATION

_____ _____

NAME SIGNATURE

- ☐ **I am not employed** at this time and if I become employed, I will complete a new "Working Spouse Affidavit" to terminate coverage for myself as of the date that coverage is available to me through my employer.
- ☐ **I am employed** at this time and authorize my employer to complete the information on this form.

SECTION 3: EMPLOYEE CERTIFICATION

I Hereby Affirm That The Response Provided Above Is True, Accurate And Correct. I Understand As An Employee Of The University Of The Cumberlands That Submitting A Form Containing Inaccurate, False Or Deceptive Statements Is Fraudulent And Will Result In Disciplinary Action.

_____ ____-____-_____

EMPLOYEE SIGNATURE DATE

SECTION 4: EMPLOYER CERTIFICATION

Dear Employer:

Effective November 1, 2014, the University of the Cumberlands Employee Health Benefit Plan will no longer permit working spouses with available PPACA compliant employer sponsored coverage to be covered on the University of the Cumberlands Employee Health Benefit Plan. For verification purposes, the spouse's employer must complete this "Working Spouse Affidavit" and return the completed form to:

University of the Cumberlands Human Resources Department
6184 College Station Drive
Williamsburg, Kentucky 40769

Please verify the following information:

- ☐ We **Do Not Offer** Medical Coverage.
- ☐ We Offer Medical Coverage But This Employee **Is Not Eligible** Because: _____
- ☐ We Offer Medical Coverage And This **Employee Is Eligible** To Enroll On: ____-____-_____
- ☐ We Offer Medical Coverage And This **Employee Is Enrolled** Effective: ____-____-_____
- ☐ We Offer Medical Coverage And This **Employee Has Chosen Not To Enroll**

Company Name: _____

Company Benefits Representative: _____ _____

NAME SIGNATURE

____-____-_____ ____-____-_____

TELEPHONE DATE