AFFIDAVIT OF SPOUSAL HEALTH CARE COVERAGE

This Affidavit MUST be completed for consideration to cover a spouse.

Employee Name:		**Department:**	
Spouse Name:			

Any spouse who is eligible for Medical & Dental Benefits under any other employer-sponsored health plan is NOT eligible to be covered under Newton County's Plan.

1. Is your spouse currently employed?

☐ Not Employed

- *Sign and return this form*

☐ Employed and Eligible Through Employer Offered Health Insurance Plan

- *Your spouse is not eligible for Newton County coverage*

☐ Employed and Not Eligible For Employer Offered Health Insurance Plan

- *Your spouse's employer must provide a letter stating your spouse isn't eligible for coverage. Return this form with the letter.*

☐ Employed and Employer Does Not Offer a Health Insurance Plan

- *Your spouse's employer must provide a letter stating they do not offer health insurance. Return this form with the letter.*

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 Newton County Benefits Plan coverage. I understand that I must supply this affidavit along with any supporting documentation to Human Resources within 30 days of my hire date.

_____ _____

Employee Signature *Date*

_____ _____

HR Authorized Signature *Date*

Please return this form to Human Resources. For any questions or concerns, contact HR @ (678)625-1212