SECTION 1: BEREA COLLEGE EMPLOYEE INFORMATION

**BEREA COLLEGE EMPLOYEE HEALTY BENEFIT PLAN**

**Working Spouse/Partner Affidavit**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *B#*

*Name*

 SECTION 2: SPOUSE/PARTNER INFORMATION

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Spouse/Partner Signature*

*Name*

* I am not employed at this time and if I become employed, I will complete a new “Working Spousal/Partner Affidavit” to terminate coverage for myself as of the date that coverage is available to me through my employer.
* I am not employed at this time but I have access to medical coverage.
* I am employed at this time and authorize my employer to complete the information in Section 4 below on this form.
* Both my spouse/partner and I are employees of Berea College.

SECTION 3: BEREA COLLEGE EMPLOYEE certificationCERTIFICATION

I hereby affirm that the response provided above is true, accurate and correct. I understand as an employee of Berea College that submitting a form containing inaccurate, false, or deceptive statements is fraudulent and will result in disciplinary action.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Employee Signature*

*Date*

SECTION 4: SPOUSE/PARTNER EMPLOYER CERTIFICATION

Dear Employer:

Effective July 1, 2014, the Berea College Employee Health Benefit Plan will no longer permit working spouses/partners with available PPACA compliant employer sponsored coverage to be covered on the Berea College Employee Health Benefit Plan. For verification purposes, the spouse’s/partner’s employer must complete this “Working Spouse/Partner Affidavit” and return the completed form to:

Human Resources Department

Berea College

CPO 2189

Berea, Kentucky 40404

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**

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Benefits Representative:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature*

*Name*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Date*

*Telephone*