BALL STATE UNIVERSITY

BSU ID: _____

Working Spouse Affidavit

Name of Employee: _____ Name of Spouse: _____

Important: please ensure this form is fully completed.
Your response, or lack of response, will impact your spouse's health care coverage.

SECTION I: Spouse Employment Information

Is your spouse currently employed?

- ☑ Yes (continue to Section II)
- ☐ Self-employed (continue to Section III, sign & date)
- ☐ Not employed / Retired (continue to Section III, sign & date)
- ☐ Employed by Ball State (continue to Section III, sign & date)

Effective January 1, 2013, if your spouse is working full time, and his or her employer offers group health care coverage, and the employer funds at least 60 percent of the coverage, your spouse will lose eligibility for primary healthcare coverage and you cannot cover your spouse as a dependent on Ball State's health plan unless he or she is also enrolled in their employer's group health plan.

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

NOTE: this section must be completed in full by your spouse's employer

1. Is the Spouse named above employed in a health benefits eligible position with your company? ☐ Yes ☐ No
   If yes, does the company pay at least 60% of the "employee only" premium? ☐ Yes ☐ No
2. Is the Spouse employed full-time with your company? ☐ Yes ☐ No
   If yes, how many hours per week does the Spouse work? _____ hours
3. Is the Spouse currently enrolled on your company's health plan? ☐ Yes ☐ No
   If you answered "Yes" when was the effective date of coverage? _____/_____/_____
4. Please indicate if your company will consider your employee's loss of eligibility under Ball State's health plan as a HIPAA special enrollment event whereby allowing your employee to join your employer-sponsored health plan. ☐ Yes ☐ No

   If you answered "No" to question 4 above, what is the earliest date that your employee will be allowed to enroll in your employer-sponsored health plan? _____/_____/_____

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 Ball State University Employee

I hereby certify that all information above is complete and true.

_____ _____

Employee Signature *(required)* Date