Pennsylvania's STATE SYSTEM of Higher Education

Spouse Health Care Enrollment Attestation
For Employees Hired On/After July 1, 2013

For employees hired on/after July 1, 2013, a spouse's enrollment in the State System health plan is contingent upon primary coverage provided by the spouse's employer group health plan, if available/applicable, regardless of the cost to the spouse, and regardless of whether the spouse has been offered an incentive to decline coverage.

This attestation is required initially when the spouse is enrolled in a State System health plan and will require recertification subsequently on an annual basis.

Employee Name:_____ Spouse Name: _____

Section I: Spouse Employment Status

My spouse is:

Employed ☐ (Go to Section II) Retired, Self-Employed, or Unemployed ☐ (Go to Section IV)

Note: A spouse is not self-employed if they receive a W-2.

Section II: Additional Employment Information (Complete this section **only** if your spouse is employed.)

Spouse's Employer: _____

Employer Address: _____

Employer Phone Number: _____

Is your spouse eligible for health care coverage through their employer?

Yes ☐ (Continue to next question) No ☐ (Go to Section IV; Spouse - Employer Information Form required)

Is your spouse enrolled in their employer's health plan?

Yes ☐ (Go to Section III) No ☐ (Continue to next question, Spouse - Employer Information Form required)

If previous answer was "No", provide the date when your spouse may enroll in their employer's health plan. _____

Section III: Spouse Health Care Coverage

Insurance Provider:_____

ID/Policy Number: _____

Policy Effective Date: _____

Section IV: Must be read and signed by employee

I declare that all information above is true and correct to the best of my knowledge. If my spouse's employer offers group health coverage, my spouse must enroll in their employer's plan regardless of any cost to my spouse. I understand that if my spouse does not enroll, they may be ineligible to be covered as a dependent in the State System health plan. I further understand that my spouse's group health plan from their employer is their primary insurance plan. I understand that eligibility for coverage and payment of benefits under the State System health plan in all instances is subject to the terms of the plan and that any false or misleading information I provide regarding the status of any dependent and any other medical or supplemental coverage that may be applicable may result in the suspension or termination of coverage under the health plan and may require repayment to the plan of any benefits paid under the plan. I understand that I must inform my employer of any changes in the employment status of any dependents which may affect their eligibility under the plan and that my failure to do so may result in the loss of coverage and repayment of any amounts paid on their behalf. If my spouse's employment and/or eligibility for health care coverage changes, I will notify my University's Human Resources Office immediately. I also understand that I may be required to provide further documentation in the event of a dependent eligibility audit.

Employee Signature (Required): _____ **Date**: _____

HR Use only:

Spouse – Employer Information Form Provided: Yes ☐ No ☐ SAP Updated:

Follow-up date: _____

Final follow-up date: _____

revised 3/11/21