2015 Spousal Waiver
Employee Statement

_____ _____

Employee Name **Department**

In an effort to control costs a Spousal Waiver has been instituted for employees covered under the healthcare plan whose spouses are eligible for healthcare insurance through their employer. The criteria are as follows:

1. Spousal Waiver applies only to employees that cover their spouse on the County Healthcare Program.

2. Eligible employee's spouse maintains full time employment and is eligible for an employer sponsored health plan through their full time employment.

Please check **only one** of the coverage options below:

☐ *Does Not Apply*

I am enrolled for single coverage, (or)
My spouse is self-employed, (or)
My spouse is employed part-time, (or)
My spouse is not employed, (or)
My spouse's employer participates in the County Healthcare Program

☐ *Spousal Coverage**

I attest to the fact that my spouse does not have access to employer-sponsored medical coverage and/or is not eligible for such coverage. Should these circumstances change, and my spouse does become eligible for employer-sponsored coverage under another employer, I must notify the County within 30 days of such occurrence. My spouse will be required to seek medical coverage under his/her current employer's plan at that time he/she becomes eligible.

I agree to notify the County regarding my spouse's eligibility for another employer-sponsored medical plan, and I attest to the truth regarding my spouse's current eligibility.
***(MUST COMPLETE SPOUSE'S EMPLOYER STATEMENT OF COVERAGE)**

☐ *Spousal Waiver **

I acknowledge that my spouse is eligible for coverage with her/his current employer. I will not cover my spouse as a dependent under my County medical insurance policy
***(MUST COMPLETE SPOUSE'S EMPLOYER STATEMENT OF COVERAGE)**

I agree to notify the County immediately if my above circumstances changes (i.e.: marriage, divorce, spouse becomes eligible for coverage elsewhere, etc.). I understand if I fail to notify the County of my change in eligibility status, I may be subject to any consequence set forth by in accordance with the County Health Insurance Guidelines (up to and including termination).

_____ _____

Employee Signature Date

**** Contact Benefits Office for Employer Statement of Coverage***

2015 Lake County
Spouse's Employer Statement of Coverage

Lake County Employee Information (Please Print Clearly):

Lake County Employee Name: _____

Lake County Employee Social Security Number: _____

Spouse Name ("Spouse"): _____

Spouse Company Name ("Company"): _____

To Be Filled Out by Spouse's Employer Representative:

I , _____ ("Representative") do hereby acknowledge that the above
Print Company Representative Name

spouse is currently an employee of _____ ("Company").
Print Company Name

Our Company currently (select ONLY one situation):

_____ **A.** does not offer any employer sponsored healthcare plan at this time.

_____ **B**. offers an employer sponsored healthcare plan but the above named Employee does not qualify to participate in plan.

_____ **C.** offers an employer sponsored healthcare plan and the above named Spouse currently **does not** participate in that plan. I understand that the above named Spouse will be eligible to elect coverage as a qualifying event. Plan information is as follows:

[1]Healthcare Insurance Carrier's Name: _____
[1]Date of Open Enrollment: _____

I do hereby attest that the above information is complete and accurate to the best of my knowledge:

	Spouse's Company Representative	Lake County Employee	Employee's Spouse
Signature:	_____	_____	_____
Date:	_____	_____	_____