Spouse/Domestic Partner Employment Affirmation

(For purposes of Benefit Plan Administration)

Please check the appropriate box below:

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1. ☐ My covered spouse/partner is not employed.

2. ☐ My covered spouse/partner is employed, but does not have Medical/Rx coverage available to him/her.

   Spouse's Employer: Name: _____

   Address: _____

   Phone:

   _____

3. ☐ My covered spouse/partner is employed full time, and has Medical/Rx coverage available to him/her. I understand that I will be assessed a surcharge in the form of higher payroll deductions to include my spouse/partner.

I acknowledge that the above information is true and correct. In addition, I agree to notify Human Resources within thirty (31) days of any event, which results in a change to the above information.

Employee Name:

Employee Signature: _____ Date:
