

WORKING SPOUSE AFFIDAVITName of Employee: _____
(print)Name of Spouse: _____
(print)

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

SECTION 1: Spouse Employment Information

- Is your spouse currently employed?
- Yes (continue to Section 2)
- Self-employed (continue to Section 3, initial & date)
- Not employed / Retired (continue to section 4)
- Employed by Vincennes University (continue to section 4)

Effective January 1, 2017, if your spouse is working and eligible for his or her employer's group health care coverage, and his or her employer has a working spouse provision for spousal coverage, your spouse will lose eligibility for healthcare coverage. You cannot cover your spouse as a dependent on Vincennes University's health plan.

SECTION 2: Employee Certification of Spouse's Health Benefit Coverage

1. Is the spouse named above employed in a health benefits eligible position with his or her employer? Yes No
2. Does the Spouse's employer have a working spouse provision (spousal carve out) in effect? *If you are uncertain, please contact that employer's Human Resources or Benefits Department.* Yes No
3. Please provide the following information:

Spouse's Employer: _____

Address of Employer: _____

SECTION 3: Self Employed Spouse

Benefits will not be payable for any of, but not strictly limited to, the following:

Employment-Related Conditions / Workers' Compensation / - Charges incurred as the result of or in connection with any activity pertaining to any act of employment for profit, gain, or compensation subject to W-2 or 1099 income from an Employer, or for which you should file a self-employment schedule for federal income taxes; or charges incurred as the result of a disease, illness, or condition for which benefits are payable under any commercial liability insurance, Workers' Compensation Act, any Occupational Diseases Act or any other similar such benefit program; services or supplies for the treatment of work related illness or injury; regardless of the presence or absence of workers' compensation coverage.

Initial _____

SECTION 4: Employee Acknowledgment

I hereby certify that all information is complete and true. If my spouse's employment status changes in the future, I understand that I am responsible for completing a new enrollment form and the Working Spouse Affidavit within 31 days of the employment status change. I understand that failure to notify Vincennes University of my spouse's employment change or falsifying his/her employment status is fraud and could result in financial penalty, loss of coverage and/or possible termination of employment.

Employee Signature (required)_____
Date