Working Spouse Affidavit

Effective 1/1/2025, if your spouse is eligible for health insurance through their employer, they are **not** eligible to enroll on Applied Mechanical Systems plan. **Completion of this form and supporting documentation is mandatory to continue spousal coverage.**

1. Is your spouse employed?
   - ☐ Yes (Complete questions two and three.)
   - ☐ No

2. Is your spouse offered health insurance through his/her employer?
   - ☐ Yes, meaning my spouse will not be on my AMS Health Insurance Plan
   - ☐ No (Proof requirement e.g., signed statement from spouse's employer on letterhead indicating health insurance is not offered.)

3. If your spouse is self employed does your spouse offer health insurance to his/her employees?
   - ☐ Yes, meaning my spouse will not be on my AMS Health Insurance Plan
   - ☐ No, my spouse is not self employed.
   - ☐ No coverage is not offered (Proof requirement e.g., signed statement on company letterhead indicating health insurance is not offered).

Complete and return this form with any supporting documentation to Brian, Emily or Lisa in the Human Resources Department by 12/13/24. **Your spouse is not eligible for coverage without this form and proper documentation.**

Note, if your spouse loses or obtains health insurance through an employer, you have 30 days from the date the coverage change occurred to notify the Human Resources Department in writing of such change. Notification should include: change in eligibility/coverage status, to include impacted dependents if applicable, and the date the change occurred. Failure to notify Human Resources within 30 days from the date the change occurred prohibits any requested changes until the next open enrollment period.

Employee Acknowledgement

My signature below indicates the facts set forth on this form are true and complete to the best of my knowledge. I also understand that if my spouse's eligibility for other group health insurance changes, it is my responsibility to notify Human Resources in writing within 30 days of such change. Any false statements written on this form or on future forms as it relates to spousal health information shall be considered grounds for disciplinary action and/or rescission of coverage.

Employee Printed Name _____

_____ _____

Employee Signature Date Signed