2025 Affidavit of Spousal Health Care Coverage

Children's of Alabama®

Employee Name: (printed) _____ Employee ID: _____

Spouse Name: (printed) _____ Phone #: _____

Section I: Spousal Benefits

To carry medical coverage for your spouse for the 2024 plan year, you must complete this affidavit and return to Human Resources within your enrollment period deadline. Please answer the following questions completely. Your response or lack thereof may impact the health care coverage of your spouse.

Is your spouse employed? (check the box that applies)

☐ Yes. You must have your spouse's employer complete Section II of this form.

☐ Yes, self-employed with no access to Group Benefits. Proceed to Section III. No further action needed.

☐ Yes, employed by Children's of Alabama. Proceed to Section III. No further action needed.

☐ No, my spouse is not employed. Proceed to Section III. No further action needed.

Please note that if your spouse's employer provides health care benefits and pays 50% or more of the costs for "employee only" or single coverage, your spouse is NOT eligible for primary coverage through your Children's of Alabama plan. However, he or she may maintain secondary coverage through this plan.

If your spouse does not qualify for primary coverage through our COA plan you may elect secondary coverage:

I elect secondary coverage for my spouse. ☐Yes ☐No

Spouse's primary insurance carrier: _____

Group #: _____

Subscriber #: _____

Submit a copy of your spouse's insurance ID card through his or her employer (primary coverage) with this completed affidavit.

Section II: Certification of Spousal Employment

Please have your spouse's employer complete the section below:

1. Is the employee eligible for health care benefits? ☐Yes ☐No
2. What portion of the "employee only" or single coverage is paid by the employee and by the employer?

   Employee: _____ Employer: _____ (This amount should add up to 100%)

Name of Employer: _____ Address: _____

Representative Name: _____ Phone: _____

Representative Signature: _____ Date: _____

Section III: Acknowledgement (By Children's of Alabama Employee)

I certify under penalty of perjury, that the foregoing is true and correct. I understand as an employee that willful falsification of information on this Affidavit may lead to disciplinary action, up to and including termination. Fraud or intentional misrepresentation may result in retroactive termination of my spouse's medical coverage.

Employee Signature: _____ Date: _____

Return completed forms to Benefits@childrensal.org or fax 205-638-5005