Northeast Ohio
MEDICAL UNIVERSITY

Spousal Exclusion Affidavit

Employee Certification Part I

NEOMED Employee Name (print):_____

NEOMED Employee Number (print):_____

Spouse Name (print):_____

Spouse Information (check one):

- ☐ Self Employed
- ☐ Unemployed
- ☐ Retired
- ☐ Medicare Enrolled
- ☐ Employed in a benefits eligible position at NEOMED.
- ☐ Employed, but does not qualify for or is not offered group health insurance.
- ☐ Financial hardship exception aligned with the Affordable Care Act legislation.
- ☐ Provider availability is not accessible due to the coverage area.

I certify that the above information and election is true and correct to the best of my knowledge. I acknowledge that any false information made on this form as it relates to spousal health insurance eligibility may lead to termination of benefits. I also understand that NEOMED will complete periodic audits and reserves the right to request supporting documentation to verify the representations I have made in this affidavit. I also understand that if my spouse's group insurance status changes, it is my responsibility to notify the Human Resources Department within 31 days of such a change.

_____ _____

Signature Date

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Employer Certification Part II

I, _____(spouse), authorize a representative of my employer, _____, to disclose the following information to the Northeast Ohio Medical University Human Resources Department for the purpose of health insurance status verification.

Does the company provide health insurance benefits to employees? ☐ Yes ☐ No

The individual listed above is currently:

☐ Enrolled in a company sponsored health insurance ***cost per pay**_____

☐ On a waiting period, coverage will begin:_____

☐ Eligible and has declined participation in our company-sponsored health insurance plan.

☐ Part-Time Employed, not eligible for company sponsored health insurance.

Please confirm** ☐ **Yes** ☐ **No that per the Affordable Care Act (ACA)the lowest single cost available to the "spouse" does not exceed 9.02% of their W-2 wages for the calendar year.

_____ _____

Company Representative Name (please print) Date

_____ (___)_____

Employer Representative Signature Phone

_____

Employer Representative Tile/Position (please print)