^ ‰ } µ • o , o š Z Œ ((]

(Required only if you wish to cover your spouse under SHP healthcare)

Name of Employee: Employee ID:

Name of Spouse:

Important: please ensure this form is fully completed.
Your response, or lack of response, will impact the Z o š Z coverage of your spouse.

If you are a ^ } µ š Z Œ v ^ š š } u u µ v] š Ç who has elected Z o š Z Œ coverage for your spouse you must complete this form. If applicable, Ç } µ • Œ ‰ } µ • u [‰ o } Ç µ Œ š } u ‰ o ^ š š] } v X

SECTION I: Spouse Employment Information

Is your spouse currently employed?

- Yes, at an employer other than ^ } µ š Z Œ v ^ š š } u u µ (continue to Section II)
- Self-employed (continue to Section III)
- Not employed / Retired (continue to Section III)

Please note t } Œ l] v P • ‰ } µ • • U Á Z } Œ o] P] o (} Œ Z o š Z } À Œ P } š v Z Œ } o µ P] v š š Z] Œ Œ u ‰ o o } Ç Ç Z o š Z ‰ o v (} Œ v Œ } o o] v P] v š Z } o o P [• Z o š Z ‰ o v X d Z } o o P Á] o o ‰ Œ À] • u ‰ o } Ç Œ [• Z ‰ o o] v • X o] P] o] š Ç } Á •] µ o Œ ^ ‹ µ o] (Ç] v P À v š _ o o } Á e n r o l l i n C o v e r a g e w i t h t h e •] Œ š } d Z ‰ Œ š (u , µ s u Z v • } µ Œ v ‰ Œ } À]] µ u v š š] š v Z] • (o (• À Œ] P v U X

Please note ^ } µ š Z Œ v ^ š š } u u µ e n r o l l m e n t , t h e r i g h t t o P r e q u e s t i n f o r m a t i o n t o v e r i f y Z] v (} Œ u ‰] Œ E v } À]] v š Z [• } Œ I n t h e event th š š Z] v (} Œ u š • v] } v š µ Œ , t h e } o o P t h e a b i l i t y t o d e n y c o v e r a g e u n d e r š Z } o o Z P o [š Z Œ ‰ o v X

SECTION II: Employee Œ š] ( ] š] } v } (^ ‰ } µ • [• , o š Z v ( ] š } À Œ P

NOTE: this section must be completed in full by Ç } µ • Œ ‰ } µ • [• u ‰ o } Ç Œ

1. Is the spouse named above (µ o o r š] e l i g i b l e f o r u ‰ o } Ç Œ r • ‰ Z } v o š] Œ E } À Œ E t h r o u g h your company? YES NO
2. If you answered no to the previous question, will he/she become eligible at a later date? YES NO
   a. If yes, please provide the date they will become eligible for coverage: _____

Name of employer:

Address of employer:

Name of Representative (Printed): Phone: ( )

Signature of Representative:

Title: Date:

SECTION III: l v } Á o P u v š t must be signed by above-named ^ } µ š Z ^ Œ v š } u u µ v] o š Ç P Employee

I certify that the foregoing is true, correct and current. I understand as an employee that willful falsification of information on this Affidavit may lead to disciplinary action. I further acknowledge that it is my responsibility to notify the • } µ ¬ Œ . • if, at

K v } u ‰ o Z š (} Œ u š µ • š • µ u] š š } , µ u v Z • } µ Œ • (} Œ ‰ Œ } • •] v P X