[School District Name]

SPOUSE ELIGIBILITY CERTIFICATION

Employee's Name: _____

Employee's Address: _____
Number and Street City State Zip

Spouse's Name: _____ Date of Birth: ____/____/____

Please indicate whether your spouse is:

□ Not Employed □ Sole Proprietor □ Employed □ Self-Employed (but not sole proprietor) □ Retired

If your spouse is not employed or a sole proprietor, please sign and date this form where indicated below and return the completed form to the Treasurer's Office.

If your spouse is employed, self-employed (but not a sole proprietor), or retired, please provide the following information:

- Name and Address of your spouse's employer or retirement plan:
  _____
- Is group health insurance and/or prescription drug insurance available to your spouse through his/her employer or retirement plan? □ Yes □ No
  - If Yes, is your spouse enrolled in his/her employer's or retirement plan's insurance? □ Yes □ No
  - If Yes, please provide the following information:
    Name and Address of your spouse's employer's or retirement plan's insurance carrier:
    _____

    Policy Number: _____ Policyholder: _____

    Group Number: _____ Insurance Covers: □ Medical □ Drug □ Dental □ Vision

Certification and Signature

If you submit false information in this Certification, you may be subject to disciplinary action up to and including termination of employment.

I hereby certify that all information provided in this Certification is correct to the best of my knowledge, and authorize the release of any information requested with respect to this Certification. I understand the District may rescind my spouse's health care coverage on the basis of fraud or intentional misrepresentation in accordance with applicable law.

_____ / _____
Signature of Employee Date