Working Spouse Affidavit

Sumner County Employee Benefits – Finance Department

Effective January 1, 2013 this form is required to be completed in full and accompany the medical enrollment form when an employee is enrolling a spouse (or seeking to continue enrollment of a spouse) in the Sumner County Insurance Trust Medical coverage (the "County Plan"). **No Spouse will be eligible or be enrolled in the County Plan until this form is completed and returned.**

EMPLOYEE INFORMATION

Employee Name: _____ Employee SS#: ***-**-(_____)

Spouse Name: _____

Please CIRCLE appropriate option number:

1. My Spouse is not actively working or is self-employed. *If the spouse is not actively working or self-employed, the employee will not be charged the additional surcharge.*

2. My Spouse is actively working but is not offered medical insurance coverage. *If the spouse is not offered insurance coverage, the employee will not be charged the additional surcharge.*

3. My Spouse works for Sumner County Board of Education in a full-time classified position OR for Sumner County Government which is also eligible for coverage by the County Plan. *If the spouse is otherwise eligible for the county plan, the employee will not be charged the additional surcharge.*

4. My spouse is working and has elected coverage through his/her employer as primary coverage and is enrolling in the County Plan as secondary coverage. ***If the spouse elects coverage under the County Plan, the employee will be charged the designated contribution set by Sumner County for the number of dependents enrolled plus an additional $100.00 monthly surcharge for the enrollment of the spouse.***

5. My spouse is working and has declined coverage through his/her employer and is enrolling in the County Plan as primary coverage***. If the spouse declines health coverage through his/her employer and elects coverage under the County Plan, the employee will be charged the designated contribution set by Sumner County for the number of dependents enrolled plus an additional $100.00 monthly surcharge for the enrollment of the spouse.***

By signing below, I represent and warrant that all information provided is accurate, current and complete to the best of my knowledge. I understand that falsification of information regarding the spouse's available coverage will result in, at a minimum, DOUBLE the additional premium surcharge being assessed retro-actively back to the date of the spouse's enrollment in the County Plan and DOUBLE the additional premium surcharge to continue coverage or permanent termination of the spouse from the County Plan. In addition, willful provision of false information may result in disciplinary action against the employee, up to and including, termination. **I also understand that if the status of medical coverage for my spouse changes, it is my responsibility to notify the Sumner County Benefits Department within 30 days of the change.** If the Spousal Surcharge is to be discontinued due to a change, there will be no refund of the previous Spousal Surcharge deduction if the Sumner County Benefits Department is not notified within 30 days of the change. The refund will not exceed the effective date of the event.

Employee Signature: _____Date: _____