Last 4 of SSN:

Spouse Coverage Affidavit

*This must be signed only if you are requesting coverage for your spouse on the Company’s medical insurance plan. By completing this affidavit, you are confirming that your spouse does not have group medical insurance coverage available through their employer.*

By signing below, I (print name), certify that my spouse does not have group medical insurance available to them through their employer. I understand that if it is found that the information I have provided is not truthful, complete or accurate, I agree that (i) I may be subject to disciplinary action up to and including termination of my employment, and (ii) my spouse will be removed from the insurance plan on the earliest date possible and that I may be responsible for paying claims that were previously paid by the plan.

Signature Date

Send completed Form to Human Resource Dimensions