SAINT LOUIS UNIVERSITY. EST. 1818

Medical Healthcare Affidavit

(Required only if you wish to cover your spouse under your UHC medical insurance)

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 medical coverage of your spouse.

If you are a Saint Louis University employee who is electing spouse coverage under United Healthcare and your spouse is employed at an employer other than Saint Louis University, you must complete this form.

If your spouse is self-employed, employed at Saint Louis University, not employed or retired, you will complete the form electronically in Workday.

Please note that if your spouse's employer provides **qualifying group medical coverage*,** which includes preventative care, major medical and prescription drug benefits, and your spouse's employer contributes at least 50 percent of the total premium for single coverage, your spouse must enroll in the spouse's employer's plan. If all the previously stated criteria are met, your spouse will no longer be eligible for coverage under United Healthcare through Saint Louis University. This loss of eligibility would be considered a "qualifying event" allowing your spouse to enroll in coverage with the spouse's employer.

Please note Saint Louis University reserves the right to request information to verify the stated criteria are met. In the event the supporting documents do not meet the University's stated criteria, the University can deny coverage under United Healthcare through Saint Louis University.

SECTION I: Employer Certification of Spouse's Health Benefit Coverage

NOTE: this section must be completed in full by <u>your spouse's employer</u>.

1. Is the spouse named above eligible for medical benefits through 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 II: Acknowledgement – must be signed by above-named Saint Louis University 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 Human Resources if, at any future date, the information provided above changes

_____ _____

Employee Signature (required) Date

Please submit the form as an attachment in the Benefits event in Workday. Please call 314-977-2595 or email benefits@slu.edu should there be any questions.