



Affidavit of Spousal Health Care Coverage



This Affidavit must be completed for consideration to cover a spouse.

Employee Name:		Employee SSN:	
Spouse Name:		Spouse SSN:	

To be completed by employee electing to enroll a spouse in coverage.

Pursuant to Arkansas Code §21-5-407(4), any spouse who is offered coverage for Medical Benefits under any other employer-sponsored health plan is NOT eligible to be covered under the Plan.

- Is your spouse currently employed?
 - Yes** (If yes, please proceed to question #2)
 - No** (If no, sign and return this form along with your election form and a copy of your Marriage License.)
- Is your spouse currently employed by an Arkansas state agency or public school district?
 - Yes** (If yes, sign and return this form along with your election form and a copy of your Marriage License.)
 - No** (If no, proceed to question #3)
- Does your spouse's employer offer health insurance coverage?
 - Yes** **No**
- Is your spouse covered by his/her employer sponsored health plan?
 - Yes** **No**
 - * If No, please submit information from your spouse's employer as to why your spouse is not covered.*
- Does your spouse's employer sponsored coverage meet the Affordable Care Act (ACA) minimum guidelines?
 - Yes** **No**
 - * If No, please provide information from your spouse's employer stating that coverage does not meet ACA guidelines.*

For any questions or concerns, contact EBD Member Services at 1-877-815-1017x1

By signing this affidavit, I certify that the information provided above is accurate. I understand that any misrepresentation in the information I provided above will permit the Plan to terminate my coverage. If applicable, I authorize the release of the information noted above, and agree to its use in the application process for ARBenefits plan coverage.

Employee Signature: _____

Date: _____

Spouse Signature: _____

Date: _____

Employee Benefits Division - ARBenefits

P.O. Box 15610 * Little Rock, AR 72231 * 877.815.1017

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