SPOUSE HEALTHCARE ELIGIBLITY AFFIDAVIT

Employee Name:	Employee ID:
Spouse Name:	School District: Bartlett City Schools

Section A: Must complete to enroll your spouse in Group Health Plan Coverage.

☐ **1** Spouse is not employed or is Retired

☐ **2** Spouse is an employee of one of the Municipal School Districts of Cities listed below: (Please check one)

- ☐ Arlington Community Schools
- ☐ Collierville Schools
- ☐ City of Bartlett
- ☐ City of Lakeland
- ☐ Bartlett City Schools
- ☐ Lakeland School System
- ☐ Town of Collierville

☐ **3** Spouse is employed or self-employed ***WITHOUT*** access to coverage from his/her employer (**MUST COMPLETE SECTION B**)

☐ **4** Spouse is employed ***WITH*** access to coverage from his/her employer but employer pays less than 50% of the cost (**MUST COMPLETE SECTION B**)

NOTE: ***If none of the above applies then he or she is not eligible for the Group Health Plan. (He or she is eligible for other benefits such as dental, vision, life.)***

I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit my employer to terminate my spouse's coverage and seek any other legal remedies available including possible prosecution for insurance fraud. If applicable, I authorize the release of the health care plan coverage information requested below and authorize its use in accepting the application for the Group Health Plan coverage.

Employee Signature:	Date:
Spouse Signature:	Date:

Section B: Must be completed by spouse's employer. (or spouse if self-employed)

Is the person named above as Spouse *eligible* for coverage with your company?

☐ Yes ☐ No

If yes, does your employee's share, ***exceed 50%*** of the total cost of premiums for your cheapest individual coverage?

☐ Yes ☐ No

Employer Name:____________________________________ Employer Phone:__________________

Employer Address:____

Authorized Employer Name:___________________________Title___________________________

Authorized Employer Signature:___________________________________ Date:_______________

Please return completed document to the Employee Benefits office:
Email: benefits@bartlettschools.org; (Fax) 901-202-0854;
(Ofc.) 901-202-0855, Ext. #2242; #2253 if you have questions

Revised 03-22-2021