**3505 W. Lincolnshire Blvd.**

**Toledo, OH 43606**

TREASURER’S OFFICE

PAYROLL



**WORKING SPOUSE AFFIDAVIT**

Phone: 419-473-8244

Fax: 419-473-8247

WLS Employee Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (please print)

Spouse Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (please print)

**A. Who must complete this form?**

Employee ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paramount Subscriber No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are a full-time Washington Local employee who is married (as defined and governed by Ohio Law) and elect WLS health coverage for your spouse, you must complete section B of this form. **If your spouse is employed, your spouse’s employer must complete section C.** The spouse eligibility requirements are as follows:

* The spouse is employed **and**
* The spouse’s employer offers health care coverage **and**
* The spouse is eligible for coverage at 50% or less of the contribution toward a single policy
* **When all three of these conditions are met, a spouse is required to enroll in at least a single coverage plan with his/her employer.**

**B. Please check the applicable qualification:**

 My spouse is: If:

 \_\_\_\_\_ employed full-time ­­ \_ unemployed

 \_\_\_\_\_ employed part-time \_\_\_\_\_ retired/not working

 \_\_\_\_\_ self-employed \_\_\_\_\_\_ employed by Washington Local Schools

 \_\_\_\_\_ disabled **Complete Part B only and return**

I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit the Washington Local School District to terminate the spouse’s coverage and seek any other legal remedies available including possible prosecution for insurance fraud. I further understand that I must report any changes in my spouse’s employment status to Washington Local School Districts Payroll/Insurance secretary.

WLS Employee Signature

**C. Eligibility for Other Benefits Coverage**

Date

I authorize the release of the health care plan coverage information requested below and authorize its use in accepting the a application for Washington Local School health benefit coverage.

Spouse Signature

Date

***TO BE COMPLETED BY SPOUSE’S EMPLOYER ONLY:***

1. Is the person named as spouse above employed (full-time or part-time)?

 **NO** If no, **STOP**. You do not need to complete the rest of this form. Please sign, date and

return to the address listed above.

 **YES** If yes, continue to question 2.

2. Does the person named as spouse receive a stipend or other incentive(s) compensation to not enroll in your health care plan?

 **NO** If no, continue to question 3.

 **YES** If yes, continue to question 3.

3. Do you offer the person named as spouse a single health plan that is 50% or less employee paid?

**PLEASE PROVIDE: Employer pays % of the premium. Employee pays % of the premium.**

 **NO** If no, **STOP**. You do not need to complete the rest of this form. Please sign, date and return to the address above

 **YES** If yes, please provide percentages and continue to question 4

4. Has the person named as spouse above taken the coverage for which he or she is eligible?

 **NO** If no, date coverage was waived or cancelled

 **YES IF YES, PLEASE PROVIDE COVERAGE INFORMATION:** Single

Family

Eff. Date

Insurance Company

Group #

Policy #

Company Name

Company Address

Authorized Employer Name

(please print)

Date \_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_

Fax \_\_\_\_\_\_\_

Authorized Employer Signature

Title

**Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)**

Revised 3/14/2023