



All eligible, married, employees who enroll for spousal medical coverage, must complete this form.

## Spousal Coverage Affidavit

For the plan year beginning January 1, 2024, the Columbus Consolidated Government will impose a **\$356.98 per month or \$164.76 biweekly surcharge** above the premium rate for all active employee/Pre-65 retiree premium plans including the Silver and Gold Plan. This surcharge is subject to change annually. The surcharge applies to employees/Pre-65 retirees, hereafter referred to as Applicants who elect to cover their working spouses who are eligible for group medical coverage through his/her own employer (other than through Columbus Consolidated Government agencies), or spouses that are retired and have access to a group health plan through his/her previous employer (other than through Columbus Consolidated Government agencies). If, at any point, a spouse ceases to be eligible for his/her employer's medical coverage, he/she may be enrolled under Applicant's Columbus Consolidated Government medical plan coverage and will not be subject to the surcharge above the premium rate. Applicant will have 30 days from the loss of coverage to enroll a spouse under the City's plan.

**Please complete and return this affidavit to Human Resources within 31 days of employment or qualifying event.**

**If you do not return the Affidavit, your spouse will not be eligible for coverage.**

### SECTION A

Employee Name:	Last 4 digits of SS#
Spouse Name:	Last 4 digits of SS#

**Please read all 4 options and check one:**

\_\_\_\_ My spouse is **unemployed** and will be covered under the Columbus Consolidated Government medical plan. **The \$356.98 per month/\$164.76 biweekly surcharge WILL NOT apply. Applicant Directions: Applicant will need to provide a wage inquiry statement from the Department of Labor or prior year tax return.**

\_\_\_\_ My spouse is employed with the Columbus Consolidated Government or a CCG agency such as the Airport, Golf Authority, Naval Museum or Trade Center. **The \$356.98 per month/ \$164.76 biweekly surcharge WILL NOT apply.**

**Spouse's Name:** \_\_\_\_\_ **Department:** \_\_\_\_\_

\_\_\_\_ My spouse is **employed/self-employed but not eligible** for group medical coverage through his/her own employer and requests to be covered under the Columbus Consolidated Government's self insured medical plan. You will need to have your spouse's employer complete Section B. If your spouse's employer indicates group health insurance is not available, **the \$356.98 per month/ \$164.76 biweekly surcharge WILL NOT apply. SECTION B MUST BE COMPLETED.**

\_\_\_\_ My spouse is **employed or retired and eligible** for medical coverage through his/her own current or previous employer. **The \$356.98 per month/ \$164.76 biweekly surcharge WILL apply.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

### SECTION B

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

1. Is the spouse listed above eligible for group health insurance?  Yes  No

Company Name \_\_\_\_\_ Date \_\_\_\_\_

Company Address \_\_\_\_\_ Phone \_\_\_\_\_

Authorized Representative Name \_\_\_\_\_ Fax \_\_\_\_\_

(Please print)

Authorized Representative Signature \_\_\_\_\_ Title \_\_\_\_\_

Participation Requirements and Terms of Agreement:

- Applicants may certify that the spouse covered by the City’s Health Plan is qualified for the Spousal Health Premium Surcharge Waiver for one of the following reason:
  1. The spouse is not employed.
  2. The spouse is employed by CCG or an agency for which we process payroll and deduct health premiums such as Airport, Golf Authority, Naval Museum or Trade Center.
  3. The spouse is employed but does not have access to employer provided group health insurance.
- Applicants agree to notify the Human Resources Department in writing within 10 days thereof, should the above-certified employment and/or employer provided group health insurance availability or enrollment status of the spouse change.
- Applicants understand that they will need to provide documentation for a qualifying event within 30 days of the event.
- Applicants authorize the Human Resources Department to obtain consumer reports on covered spouses for the purpose of identifying spousal employers.
- Applicants authorize and direct the employer of covered spouses to release information regarding health plan eligibility and enrollment to City Human Resources Department representatives.
- Applicants authorize the presentation of this document or copies thereof to employers and consumer reporting agencies for employment and health benefit verification purposes.
- Applicants understand that Human Resources may request periodic recertification of the information contained herein or conduct random audits to verify the continued accuracy of such information.
- Applicants understand and agree that the penalty for false certification to obtain a waiver of the spousal premium surcharge is expulsion of the Applicant and all covered dependents from the Columbus Consolidated Government Employee/Retiree Health Plan for a period of one (1) year from the date the false certification is discovered. During such period of expulsion, Applicants may continue plan participation at much higher COBRA rates or obtain health plan coverage elsewhere.
- Applicants understand and agree that the penalty for false certification cannot be avoided after the commencement of a false certification audit or after a false certification is discovered.

By affixing their signatures, Applicants certify that the information set forth in this affidavit is true and correct.

Printed Name of Employee	Printed Name of Employee Spouse if Covered
Signature of Employee	Signature of Employee Spouse if Covered
Social Security # or Blue Cross Member ID #	Social Security # or Blue Cross Member ID #
Mailing Address	City                      State                      Zip Code

This application and agreement signed by Employees/Retirees in the presence of a City Human Resources Department employee or a Notary Public on the \_\_\_\_ day of \_\_\_\_\_, 20\_\_ in the County/State of \_\_\_\_\_, \_\_\_\_\_.

Witness or Notary for Employee (Seal)	Witness or Notary for Employee Spouse (Seal)
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**Return via email to:** Complete on E-Forms