Affidavit of Spousal Healthcare Coverage

Employee Name		Employee SSN	
Spouse Name		Spouse SSN	

To be completed by employee electing to enroll a spouse or when dropping a spouse due to gaining employer group coverage.

Pursuant to Arkansas Code Ann. §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 ARBenefits Plan.

1. 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)

2. 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)

3. Is your spouse eligible for his/her employer-sponsored group health plan?

   Yes

   No (Letter from employer explaining why they are not eligible is required. Spouse will not be added if this is not provided.)

   My Spouse is self-employed, provide company name: ______________________

For any questions or concerns, contact EBD at 1-877-815-1017 or email Ask.EBD@arkansas.gov

By signing this affidavit I certify that the information provided above is accurate. I understand that any misrepresentations in the information I provided above will permit the ARBenefits 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: ______________________

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:
Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-0983