Roman Catholic Diocese of Albany Group
Working Spousal Affidavit

Employee Name (Please print): ____

Spouse Name (Please print): ____

Employer/Parish/School: ____
participating in the Roman Catholic Diocese of Albany Group who elects Two Person Employee/Spouse medical insurance coverage <u>must</u> complete this form.

Please circle "No" or "Yes" as appropriate to the following:

1. Is your spouse employed? **No** **Yes**

2. If circled yes to 1, is your spouse eligible for an employer sponsored health plan through his/her work? **No** **Yes**

If you answered ***yes*** to the above two questions, you will have an amount withheld from your pay in accordance with the amount noted on the Two Person Employee/Spouse table for health insurance for calendar year 2021. If you answer ***no*** to either of the above two questions, you will have an amount withheld from your pay in accordance with the amount noted on the Two Person Employee/Child table for health insurance for calendar year 2021.

Should your spouse lose coverage at their current employer at any time during the plan year, they would be eligible to enroll on the Roman Catholic Diocese of Albany Group medical plan **within 30 days**.

I hereby certify that the information on this legal document is true and correct. I understand any misrepresentation in the information I provided above will result in disciplinary action, including but not limited to: Termination of both my coverage and/or my spouse's coverage.

I will be held financially liable and responsible for reimbursing the related Employer/Parish/School of Roman Catholic Diocese of Albany Group for any costs, including all claims, incurred due to misrepresentation.

Employee Name (please print): ___________________________________

Employee Signature: _______________________________________

Date: _____________

Please sign, date and return to your employer

Updated May 2021