MANDEVILLE FIRE/EMS
SPOUSE HEALTH INSURANCE ELIGIBILITY FORM

The spouse of an employee or insurance-eligible retiree of Mandeville Fire/EMS (St. Tammany Parish Fire Protection District No. 4) may not be enrolled on a Mandeville Fire/EMS group health insurance policy if the spouse is eligible for health insurance through their own employer. This form is required to be completed in full and submitted to the Human Resource Officer upon initial enrollment of the spouse, any change to the spouse's eligibility for health insurance on the policy, and by the deadline for each annual open enrollment in which coverage is elected for the spouse with an effective date of January 1, 2017 or later.

SECTION 1: EMPLOYEE & SPOUSE

Employee's Name: _____

Spouse's Name: _____

SECTION 2: QUALIFYING QUESTIONS

Q1. Is your spouse employed?
(receiving wages or income from an individual, business, organization, etc. including self-employment)
If you answered "YES", proceed to the next question (Q2).
If you answered "NO", your spouse is eligible to participate in the group health insurance plan and you must complete the Employee Attestation in Section 3 below.

☐ Yes ☐ No

Q2. Is your spouse offered health insurance by their employer?
If "Yes", your spouse is not eligible to be covered on health insurance through MFD/EMS.
If you answered "NO", you must complete the Employee Attestation in Section 3 below and have the Verification by Spouse's Employer in Section 4 completed by your spouse's employer.

☐ Yes ☐ No

SECTION 3: EMPLOYEE ATTESTATION

By signing below, I represent and warrant that the information provided on this form is accurate, current and complete to the best of my knowledge. I understand that falsification of information regarding my spouse's employment and/or available health insurance coverage will result in disciplinary action, up to and including, termination. I also understand that if the status of my spouse's eligibility for medical coverage through an employer changes, it is my responsibility to notify the Human Resource Officer in writing within 30 days of the change.

Employee Signature: _____ Date: _____

SECTION 4: VERIFICATION BY SPOUSE'S EMPLOYER

This section should be completed by the employer, or employer representative, of the spouse listed in Section 1 above to document eligibility for health insurance through their employer. We appreciate your assistance.

1. Is the spouse listed above currently employed by your organization? ☐ Yes ☐ No
2. Is the spouse listed above eligible for health insurance through your organization? ☐ Yes ☐ No
3. Is the spouse listed above currently covered by your employer sponsored health insurance? ☐ Yes ☐ No
4. If the spouse listed above is not currently eligible for your employer sponsored health insurance, will they be elgible at a later date? If so, on what date? ☐ Yes ☐ No ☐ N/A
   Date: _____

Company Name/Employer: _____

Employer Telephone #: ( )

Owner/HR/Manager's Signature: _____

Owner/HR/Manager's Printed Name: _____