TABOR
A Family of Services

Spouse/Domestic Partner Working Affidavit

Benefit Period: November 1, 2023 to October 31, 2024

Employee Name: _____ **Employee ID Number:** _____

Please print

If your Spouse/Domestic Partner is eligible for group health insurance coverage through his/her employer's plan, he/she must participate in that group coverage and is not eligible for coverage under the Tabor Services group health insurance plan.

Spouse/Domestic Partner's Name: _____

Is your Spouse/Domestic Partner employed?

☐ Yes – Complete the remainder of this form

☐ No – Sign and date the bottom of this form
(proof may be requested – e.g.: unemployment statement, SSI payments, state assistance, etc.)

Is your Spouse/Domestic Partner offered health coverage through his/her employer?

☐ Yes ☐ No

Spouse/Domestic Partner Employer Information:

Employer Name: _____

HR/Benefits Contact & Phone Number: _____

If your Spouse/Domestic Partner is currently enrolled in his/her employer's medical plan, please provide a copy of their insurance card and attach to this form.

If your Spouse/Domestic Partner is NOT enrolled in his/her employer's medical plan, please choose from the following:

☐ My Spouse/Domestic Partner will enroll during his/her employer's open enrollment period (provide date):
_____

☐ My Spouse/Domestic Partner is a newly hired employee and not eligible for coverage until (provide date):
_____

☐ My Spouse/Domestic Partner is employed part time and does not qualify for benefits under his/her employer's plan

☐ My Spouse/Domestic Partner is self employed – proof may be requested

Attestation:

I certify that the answers I have provided on this form are true and accurate. I understand that a person may be committing insurance fraud if he/she submits a form containing false information or deceptive statements. I further understand that if it's discovered that I made false or deceptive statements on this form, I will be subject to disciplinary action up to and including termination of employment.

_____

Employee's Signature Date

_____

Employee's Spouse/Domestic Partner's Signature Date