**2021 Working Spouse – Primary Coverage Certification**

**Who must complete this form? Employee electing** medical or dental coverage for their spouse.

**When must this form be completed?** Annually during each open enrollment period and within 31 days of qualifying event.

**UA Employee Name (print):** **Emp Id #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse Name (print):­ Spouse SSN:**

**Section A - My Spouse is** (check one)**:**

[ ]  Employed Part Time *(Employer MUST complete Section B.)*  [ ]  Employed Full Time *(Employer MUST complete Section B.)*

[ ]  Not Employed [ ]  Self-Employed [ ] Retired [ ]  Full-time UA Employee

[ ]  I wish to elect **secondary coverage** for my spouse through UA. (Please sign below and return to Benefits Administration with a copy of your spouse’s primary insurance card.)

*If my spouse’s employment or health insurance coverage status changes in the future, I understand that I am responsible for contacting Benefits and completing the appropriate paperwork within 31 days of the change. I certify the above completed information is true and correct to the best of my knowledge and understand that any misstatement constitutes fraud and may result in termination of benefits and/or employment.*

*Employee Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_*

*I, as the spouse of a UA employee, authorize the release of the medical plan coverage information set forth in Section B and authorize its use in making application for UA health insurance.*

*Spouse Signature \_\_\_\_\_\_\_\_\_\_\_\_\_ Date*

**Section B – Employer Certification**

1. Is the above-named spouse eligible for your group medical health insurance? [ ]  Yes [ ]  No
2. Is the above-named spouse required to pay 50% or less of your total plan premium? [ ]  Yes [ ]  No

**If yes, the named spouse is *NOT* eligible for primary coverage under UA’s health plan and must enroll in your plan.**

**If no, the named spouse is eligible for coverage under UA’s health plan.**

1. If not already enrolled, when will the named spouse’s health coverage with you begin? \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name and Title of Individual Completing the Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name and Address \_\_\_\_\_\_

Employer Phone Number and/or Email

**The above responses are correct to the best of my knowledge.**

 \_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Employer Representative Date