



# SPOUSE/DOMESTIC PARTNER WORKING AFFIDAVIT

Benefit Period: July 1, 2026 to June 30, 2027

EMPLOYEE NAME (Please Print):

EMPLOYEE ID NUMBER:

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 Woods System of Care group health insurance plan.

SPOUSE/DOMESTIC PARTNER'S NAME (Please Print):

### 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 their employer?

- Yes
- No

### Spouse/Domestic Partner Employer Information:

EMPLOYER NAME:

HR/BENEFITS CONTACT & PHONE NUMBER:

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

- My Spouse/Domestic Partner will enroll during their 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 they submit a form containing false information or deceptive statements. I further understand that if it is 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

Spouse/Domestic Partner's Signature

Date