Coatesville Area School District – Federation
Affidavit for Spousal Health Care Coverage – 2020-2021

SECTION I

_____ ("Employee") hereby affirms that the CASD Employee's spouse,
Print Employee Name

_____ is:
Print Spouse's Name

☐ Eligible to participate in the health plan(s) offered by your spouse's employer.
(Stop here and proceed Section IV)

☐ Not eligible to participate in the health plan(s) offered by the employer OR the employer does not offer healthcare plans (Stop here and proceed to complete Section II of the form.)

☐ Spouse is self-employed and does not have an option for health benefits
(Stop here and proceed to complete Section III of the form.)

☐ Spouse is not employed

SECTION II

Company Name:_____

_____ _____
Spouse's Employer's Signature *Date*

_____ _____
Print Name *Print Title*

SECTION III

_____ ("Employer") hereby affirms that the CASD Employee's spouse,
Print Spouse's Company's Name

_____ is self-employed and does not offer a health insurance plan for him/herself or employee(s):
Print Spouse's Name

SECTION IV EMPOYEE CERTIFICATION

I understand that it is my responsibility to inform the district immediately, if the eligibility status of my spouse for the district's healthcare coverage changes. If at any time, my spouse should lose eligibility under his/her employer group medical coverage, the district will provide me the opportunity to reinstate my spouse under the district's respective plan within 30 days of such a change.

I further understand that if I have misrepresented the eligibility of my spouse's group coverage, I may be responsible for any premium and claim expense for the period of time the misrepresentation occurred.

_____ _____

Employee Signature Date