Coatesville Area School District - CATA
Affidavit for Spousal Health Care Coverage

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 the employer.
(Stop here and proceed to complete Section II of the form.)

☐ 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.)

☐ My spouse's deductible and premium share for single medical coverage is less than $1,500 per year

☐ Spouse is not employed

SECTION II

_____
Print Spouse's Name *Spouse's Employer*

☐ My spouse's deductible and premium share for single medical coverage is higher than $1,500 per year

☐ My spouse is not eligible to participate in his/her employer medical coverage

Please have your spouse's employer complete the information below

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

_____ _____
Print Name *Print Title*

_____
Provide the Very First Date of Eligibility

SPOUSE'S SELF-EMPLOYMENT CERTIFICATION

_____ ("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

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