Lake County Board of DD/Deepwood

SPOUSAL SURCHARGE AFFIDAVIT--NO OTHER COVERAGE

To be completed for all spouses WITHOUT OTHER COVERAGE for whom coverage is being requested. We will not pay the premium for a spouse who is eligible for medical insurance through any other source.

IN THE STATE OF OHIO)
) SS: AFFIDAVIT
COUNTY OF LAKE)

I hereby affirm that **MY SPOUSE DOES NOT CURRENTLY HAVE MEDICAL COVERAGE AVAILABLE TO HIM/HER THROUGH ANY OTHER SOURCE**. I understand that the Spousal Surcharge is being waived due to this status.

I understand that should my spouse be eligible to elect medical coverage through another source such as his/her employer, COSE, a retirement plan, or his/her **employer-paid** health insurance marketplace premium subsidy, I must immediately notify the LCBDD Human Resources Department of this change in status. I will then be required to remove my spouse from Agency medical insurance coverage at the earliest effective date for his/her new insurance coverage, or pay the Spousal Surcharge fee in order to continue coverage for my spouse. The Spousal Surcharge will be equal to the monthly premium difference between employee only (plus children, if applicable) coverage, and either Employee+Spouse, or Family coverage, whichever is applicable. Failure to report such coverage will result in reimbursement for the Spousal Surcharge that should have been paid. I grant the LCBDD the authority to contact the following employer in order to confirm this surcharge waiver.

Spouse's Employer, if employed:

_____

Employer's Address:

_____

_____

The contact person for their HR department is: The phone number for their HR department is:

_____ (_____)_____

THIS STATEMENT MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC.

I have read, understand, and agree to the above statements.

Print Name

_____

Signature _____ Date _____20___

FURTHER AFFIANT SAYETH NAUGHT

Sworn to and subscribed before me a Notary Public this _____ day of _____ 20___.

_____

NOTARY