Southern California Drug Benefit Fund
AFFIDAVIT of Health Care Coverage – Spouse or Domestic Partner

Participant Information:

SSN or DF#: _____

First Name: _____ Last Name: _____

Address: _____ City/State/Zip: _____ New Address? □ No □ Yes

**** Important: If you have enrolled your spouse or domestic partner as your eligible dependent you and your spouse or domestic partner must also complete and return this form to the Drug Fund office.**

Your response, or lack of response, will impact your spouse's/domestic partner's health care coverage.

SECTION 1: Spouse / Domestic Partner Information

1. First Name: _____ Last Name: _____ SSN: _____

2. Is your spouse / domestic partner currently employed?

□ Yes, currently employed, or self-employed **(circle one and continue to Section 2**)

□ No, not employed (**continue to Section 3**) □ Retired (**continue to Section 2)**

SECTION 2: Employer Certification of Spouse's or Domestic Partner's Health Benefit Coverage

NOTE: this section must be completed in full by the employer of <u>your spouse/domestic partner, OR former employer if the spouse/domestic partner is retired. Your spouse/domestic partner must sign the authorization as well.</u>

1. Is the spouse or domestic partner named above eligible to enroll for employee or retiree health benefits through their employment/prior employment?
□ Yes □ No Date of hire _____ Date eligible to enroll _____

2. If yes, is the spouse or domestic partner enrolled in healthcare coverage? □ Yes (self only) □ Yes (family coverage) □ No
Effective date of coverage: _____

3. If you answered yes to question 2 is the spouse or domestic partner enrolled in the best plan for which he/she is eligible?
□Yes □ No

Name of spouse/domestic partner employer: _____

Address of spouse/domestic partner employer: _____ City/State/Zip: _____

Authorization and Verification

I (Spouse/Domestic Partner), _____, hereby authorize my employer or former employer to release any information regarding my benefits and employment to the Southern California Drug Benefit Fund.

Signature of Spouse/Domestic Partner: _____ Date: _____

Name of Employer representative (printed): _____ Phone: (____) _____

Signature of Employer representative: _____

Title: _____ Date Signed: _____

SECTION 3: Acknowledgement and Authorization – must be signed by Participant and Spouse/Domestic Partner

I certify under penalty of perjury, that the foregoing is true, correct, and current.

Signature of Participant: _____ Date_____

Signature of Spouse/Domestic Partner: _____ Date_____