Return this form to the Department of Transformation and Shared Services: Employee Benefit Division

Mail to: P.O Box 15610, Little Rock, AR 72231
Fax: 501-683-0983
Upload on your ARBenefits Portal at: www.transform.ar.gov/employee-benefits/arbenefits

Affidavit of Spousal Health Care Coverage

This Affidavit must be completed for consideration to cover a spouse.

Employee Name:		**Employee SSN:**	
Spouse Name:		**Spouse SSN:**	

To be completed by employee electing to enroll a spouse in coverage.

Pursuant to Arkansas Code §21-5-407(4), any spouse who is offered coverage for Medical Benefits under any other employer-sponsored health plan is NOT eligible to be covered under the Plan.

1. Is your spouse currently employed?

   ☐ **Yes** (If yes, please proceed to question #2)

   ☐ **No** (If no, sign and return this form along with your election form and a copy of your Marriage License.)

2. Is your spouse currently employed by an Arkansas state agency or public school district?

   ☐ **Yes** (If yes, sign and return this form along with your election form and a copy of your Marriage License.)

   ☐ **No** (If no, proceed to question #3)

3. Does your spouse's employer offer health insurance coverage?

   ☐ **Yes** ☐ **No**

4. Is your spouse covered by his/her employer sponsored health plan?
   ** If No, please submit information from your spouse's employer as to why your spouse is not covered.*

   ☐ **Yes** ☐ **No**

5. Does your spouse's employer sponsored coverage meet the Affordable Care Act (ACA) minimum guidelines?
   ** If No, please provide information from your spouse's employer stating that coverage does not meet ACA guidelines.*

   ☐ **Yes** ☐ **No**

For any questions or concerns, contact EBD Member Services at 1-877-815-1017x1

By signing this affidavit, I certify that the information provided above is accurate. I understand that any misrepresentation in the information I provided above will permit the Plan to terminate my coverage. If applicable, I authorize the release of the information noted above, and agree to its use in the application process for ARBenefits plan coverage.

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____