TREASURER'S OFFICE
PAYROLL

WASHINGTON LOCAL SCHOOLS
3505 W. Lincolnshire Blvd.
Toledo, OH 43606

Phone: 419-473-8244
Fax: 419-473-8247

WORKING SPOUSE AFFIDAVIT

WLS Employee Name _____ (please print)

Employee ID # _____

Spouse Name _____ (please print)

Paramount Subscriber No.: _____

A. Who must complete this form?

If you are a full-time Washington Local employee who is married (as defined and governed by Ohio Law) and elect WLS health coverage for your spouse, you must complete section B of this form. **If your spouse is employed, your spouse's employer must complete section C.** The spouse eligibility requirements are as follows:

- The spouse is employed **and**
- The spouse's employer offers health care coverage **and**
- The spouse is eligible for coverage at 50% or less of the contribution toward a single policy
- **When all three of these conditions are met, a spouse is required to enroll in at least a single coverage plan with his/her employer.**

B. Please check the applicable qualification:

My spouse is:
_____ employed full-time
_____ employed part-time
_____ self-employed
_____ disabled

If:
_____ unemployed
_____ retired
_____ employed by Washington Local Schools
Complete Part B only and return

I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit the Washington Local School District to terminate the spouse's coverage and seek any other legal remedies available including possible prosecution for insurance fraud. I further understand that I must report any changes in my spouse's employment status to Washington Local School Districts Payroll/Insurance secretary.

WLS Employee Signature _____ Date _____

C. Eligibility for Other Benefits Coverage

I authorize the release of the health care plan coverage information requested below and authorize its use in accepting the a application for Washington Local School health benefit coverage.

Spouse Signature _____ Date _____

TO BE COMPLETED BY SPOUSE'S EMPLOYER ONLY:

1. Is the person named as spouse above employed (full-time or part-time)?
   _____ **NO** If no, **STOP**. You do not need to complete the rest of this form. Please sign, date and return to the address listed above.
   _____ **YES** If yes, continue to question 2.

2. Does the person named as spouse receive a stipend or other incentive(s) compensation to not enroll in your health care plan?
   _____ **NO** If no, continue to question 3.
   _____ **YES** If yes, continue to question 3.

3. Do you offer the person named as spouse a single health plan that is 50% or less employee paid?
   PLEASE PROVIDE: Employer pays _____% of the premium. Employee pays _____% of the premium.
   _____ **NO** If no, **STOP**. You do not need to complete the rest of this form. Please sign, date and return to the address above
   _____ **YES** If yes, please provide percentages and continue to question 4

4. Has the person named as spouse above taken the coverage for which he or she is eligible?
   _____ **NO** If no, date coverage was waived or cancelled _____
   _____ **YES** **IF YES, PLEASE PROVIDE COVERAGE INFORMATION:** Single __ Family __ Eff. Date _____

   Insurance Company _____
   Group # _____ Policy # _____

Company Name _____ Date _____

Company Address _____ Phone _____

Authorized Employer Name _____ (please print) Fax _____

Authorized Employer Signature _____ Title _____

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

Revised 3/14/2023