

The University of Hartford applies the following definitions as it relates to spousal coverage under only its group medical insurance plans:

Eligible Spouse – an employee’s legal spouse who ***does not have access*** to affordable health care coverage that provides minimum value (as defined by the Affordable Care Act*) through his/her employer.

Ineligible Spouse – an employee’s legal spouse who ***has access*** to affordable health care coverage that provides minimum value (as defined by the Affordable Care Act*) through his/her employer.

* The Affordable Care Act requires large employers (any company or organization that has an average of at least 50 full-time employees or “full-time equivalent” employees) to provide access to a health insurance plan to its employees (a full time employee who works at least 30 hours per week) that provides minimum value (the plan pays at least 60 percent of the total allowed costs of benefits provided under the plan) and meets the affordability test (the employee portion of the Employee Only premium for the employer’s lowest-cost coverage does not exceed 9.5 percent of the employee’s income). All employers must provide information to their employees in their health insurance plan documents and the Summary of Benefits and Coverage, informing them whether their employer-sponsored coverage meets the minimum value standard.

Note: For calendar year 2019, employees whose base earnings are less than \$40,000, if annualized, are exempt from this requirement, if applicable.

SPOUSAL ELIGIBILITY AFFIDAVIT

I certify that my legal spouse does not have access to affordable health care coverage that provides minimum value (as defined by the Affordable Care Act) through his/her employer at this time.

Spouse’s Name: _____

Spouse’s Employer: _____
(if employed)

If my eligible spouse gains access to affordable health care coverage that provides minimum value (as defined by the Affordable Care Act*) through his/her employer at a later date, I agree to notify HRD within 30 days of this access and understand that my spouse will no longer be considered eligible under the terms of the plan at that time. I further understand that I will be required to provide documentation of this change in eligibility and the effective date of access to affordable health care at that time.

I attest that the above information is accurate to the best of my knowledge as of the date that I sign and submit this affidavit. I further attest that I understand that if the above information is later found to be inaccurate that my spouse will no longer be eligible for the University of Hartford’s group health insurance plan, and that this may be grounds for appropriate disciplinary action, up to and including termination of my employment.

Employee Name (please print)

Employee Signature

University of Hartford ID Number

Date