Hocking College Other Insurance Carve Out Affidavit

(All employees must complete this form. Failure to complete this form will result in a forfeiture of benefits coverage.)

Employee Name

If you or your spouse is eligible for group health insurance, dental insurance, or vision insurance through a current or past (retirement coverage) employer, then either of you ***will not be eligible*** to obtain coverage under the Hocking College group health insurance, dental insurance, or vision insurance plans. You must complete this form to indicate your and your spouse's eligibility for participation in the Hocking College health plan.

Please note that coverage under Medicare, Medicaid and the Veteran's Administration is not subject to the spousal carve out provisions.

Are you eligible for health, dental, or vision coverage through Medicaid, Medicare, Veteran's Administration or current employer aside from Hocking College?

☐ Yes ☐ No

Do you have a spouse or significant other? ☐ Yes ☐ No

Is your spouse employed? ☐ Yes ☐ No

Is your spouse eligible for health, dental, or vision coverage through his or her employer as a current employee? Please check all that apply.

☐ Health ☐ Dental ☐ Vision

Is your spouse eligible for health, dental, or vision coverage through his or her past employer as a retiree?

☐ Health ☐ Dental ☐ Vision

Spouse Name

Spouse Date of Birth | Spouse SSN

Spouse Employer

Spouse Employer HR Contact Name | HR Phone Number

I do hereby attest that the above information is true and correct to the best of my knowledge. I understand Hocking College reserves the right to request supporting documentation and any proof as it, in its sole discretion, deems necessary in order to verify the representations I have made in this Affidavit. I also understand that if my or my spouse's group medical insurance status changes, it is my responsibility to notify Human Resources within 30 days of such change. I further acknowledge that if my spouse is covered under the Hocking College medical plan and it is later determined that my spouse was eligible for other group medical coverage through his/her employer, I may be required to repay the cost of any claims incurred by my spouse from the date of ineligibility. I further understand that knowingly falsifying this form or making any false statement or representation in connection with this form may result in retroactive payroll contribution adjustments and/or disciplinary action up to and including termination of employment.

Employee Signature | Date