SHERMAN COLLEGE *of* CHIROPRACTIC

Spouse Coverage & Attestation Form

This form must be returned to Human Resources

Your Name (print) _____ _____ _____
First Middle Last

Social Security No. _____

Address _____ _____ _____ _____
Street City State Zip

Spouse's Full Name (print) _____

Spouses who are covered under the **Sherman College Health Plan** may continue coverage if they meet one of the following conditions:

- Your spouse is unemployed, retired, part-time or self-employed with no option to elect other type of group medical coverage OR has elected medical coverage at their place of employment.

If you are electing to continue to cover your spouse, select one of the below that best meets your situation:

☐ My spouse is employed at _____ **Company** as a part-time employee and is **NOT** eligible to purchase or enroll in any other group medical coverage.

☐ My spouse is unemployed and is **NOT** eligible to purchase or enroll in any other type of group medical coverage

☐ My spouse is retired and **NOT** eligible to purchase or enroll in any other type of group coverage

☐ My spouse is also employed at Sherman College and they are enrolled on my coverage

☐ My spouse is self-employed and is **NOT** eligible to purchase or enroll in any other type of group coverage. If applicable, complete below:

Name of spouse's employer _____

Telephone number of spouse's employer _____

Your spouse's Social Security Number (required)_____

☐ My spouse is employed but my spouse's employer offers **NO** group medical coverage, and my spouse does **NOT** have the option to purchase or enroll in any other group coverage. If applicable, complete below:

Name of spouse's employer _____

Telephone number of spouse's employer _____

Your spouse's Social Security Number (required)_____

☐ My spouse is employed, and has chosen to enroll in his/her employer's medical coverage from his/her employer. If applicable, complete below:

Name of spouse's employer _____

Telephone number of spouse's employer _____

Your spouse's Social Security Number (required)_____

I hereby certify that all answers and statements on this document are true and complete. I understand that any misrepresentation or omission of facts on this attestation may be cause for disciplinary action, up to and including termination. I hereby authorize **Sherman College** to request and obtain insurance verification and information from parties outside of our Medical Plan and I release such individuals and places of business from any liability for providing such information to the **Sherman College Medical Plan**.

Failure to complete this form will result in your spouse being dis-enrolled from Sherman College's Medical Plan.

_____ _____
Employee Signature Date