



ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____
(Please Print)

Employee ID # _____

Spouse Name _____
(Please Print)

\$35.00 19 Paychecks – August 31 – May 31

Is your address different from your Spouse? (Please check one) No Yes

If yes, what is your spouse's address? _____
(Street)

(City, State, and Zip Code)

A. Who must complete this form?

If you are a full-time St. Johns County School District employee who is married (as defined by Florida Law) and elect St. Johns County School District medical coverage for your spouse/family, you **must** complete section B of this form.

Insurance Fraud Warning: Any person who, with intent to defraud, or knowing that he/she is facilitating a fraudulent act against a benefit plan, submits an application or a claim containing a false or deceptive statement is guilty of insurance fraud.

B. Please place a check next to the applicable statement:

My spouse is:

_____ employed full-time/eligible for employer-sponsored medical insurance
Employer Name _____

_____ employed full-time/not eligible for employer-sponsored medical insurance
Employer Name _____

_____ employed full-time/employer does not offer medical insurance
Employer Name _____

_____ Self-employed

_____ employed part-time/employer does not offer employer-sponsored medical insurance to part-time employees
Employer Name _____

_____ Disabled

_____ Unemployed

_____ employed by St. Johns County School District

_____ retired

If your spouse is eligible for medical insurance offered through their employer, your spouse is eligible for coverage under the St. Johns County School District Self-Funded Medical Plan only with the addition of a monetary surcharge.

I hereby certify that the information provided above is correct. I further understand that I must report any changes in my spouse's employment status and/or changes in my spouse's eligibility for employer-sponsored medical insurance to St. Johns County School District's Human Resources Department. **Failure to accurately report a spouse's employment status or changes in the spouse's eligibility for employer-sponsored insurance may result in your spouse's coverage being terminated and may be grounds for disciplinary action against you up to and including termination of employment.**

Employee Signature _____ Date _____

PLEASE RETURN YOUR COMPLETED FORM TO THE HUMAN RESOURCE BENEFITS DEPARTMENT WITH YOUR FAMILY STATUS CHANGE. Failure to return this document by the due date will result in the implementation of the spousal surcharge until such time as a form is received. At that time, the surcharge may be stopped however, refunds for any surcharge collected will not be granted.