ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

Is your address different from your Spouse's? (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 elects 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 _____

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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 BY OCTOBER 31, 2022. *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.*

ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

Is your address different from your Spouse's? (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 elects 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

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Employee Signature _____ Date _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

A. Who must complete this form?

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

A. Who must complete this form?

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Employer Name _____

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

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

A. Who must complete this form?

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Employer Name _____

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Employer Name _____

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_____ Unemployed

_____ employed by St. Johns County School District

_____ retired

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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(City, State, and Zip Code)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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(City, State, and Zip Code)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
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(City, State, and Zip Code)

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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 BY OCTOBER 31, 2022. *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.*

ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

Is your address different from your Spouse's? (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?

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
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Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
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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 BY OCTOBER 31, 2022. *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.*

ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

Is your address different from your Spouse's? (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 elects 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

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Employee Signature _____ Date _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(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 elects St. Johns County School District medical coverage for your spouse/family, you **must** complete section B of this form.

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Employer Name _____

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

A. Who must complete this form?

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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

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Employer Name _____

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_____ Unemployed

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

A. Who must complete this form?

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

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

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Employer Name _____

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_____ retired

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

Is your address different from your Spouse's? (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?

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

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Employer Name _____

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Employer Name _____

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_____ Unemployed

_____ employed by St. Johns County School District

_____ retired

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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(City, State, and Zip Code)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
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(City, State, and Zip Code)

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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 BY OCTOBER 31, 2022. *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.*

ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

Is your address different from your Spouse's? (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?

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
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Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
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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 BY OCTOBER 31, 2022. *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.*

ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

Is your address different from your Spouse's? (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 elects 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

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Employee Signature _____ Date _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(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 elects St. Johns County School District medical coverage for your spouse/family, you **must** complete section B of this form.

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Employer Name _____

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

A. Who must complete this form?

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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

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Employer Name _____

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_____ Unemployed

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

A. Who must complete this form?

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

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

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Employer Name _____

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_____ retired

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

Is your address different from your Spouse's? (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?

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

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Employer Name _____

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Employer Name _____

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_____ Unemployed

_____ employed by St. Johns County School District

_____ retired

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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(City, State, and Zip Code)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
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(City, State, and Zip Code)

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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 BY OCTOBER 31, 2022. *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.*

ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

Is your address different from your Spouse's? (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?

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
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Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
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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 BY OCTOBER 31, 2022. *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.*

ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

Is your address different from your Spouse's? (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 elects 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

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Employee Signature _____ Date _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

A. Who must complete this form?

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Employer Name _____

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

A. Who must complete this form?

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Employer Name _____

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Employer Name _____

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_____ employed by St. Johns County School District

_____ retired

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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

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(City, State, and Zip Code)

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Employer Name _____

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
(Please Print)

Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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ST. JOHNS COUNTY SCHOOL DISTRICT SPOUSE MEDICAL BENEFITS AFFIDAVIT

Employee Name _____ Employee ID # _____
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Spouse Name _____ $35.00 19 Paychecks – August 31 – May 31
(Please Print)

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