Affidavit of Spousal Healthcare Coverage

Employee Name		Employee SSN	
Spouse Name		Spouse SSN	

To be completed by employee electing to enroll a spouse or when dropping a spouse due to gaining employer group coverage.

Pursuant to Arkansas Code Ann. §21-5-407(4), any spouse who is offered coverage for Medical Benefits under any other employer-sponsored health plan is NOT eligible to be covered under the ARBenefits Plan.

1. Is your spouse currently employed?

   ☐ Yes (If yes, please proceed to question #2)

   ☐ No (If no, sign and return this form along with your election form and a copy of your marriage license)

2. Is your spouse currently employed by an Arkansas state agency or public school district?

   ☐ Yes (If yes, sign and return this form along with your election form and a copy of your marriage license)

   ☐ No (If no, proceed to question #3)

3. Is your spouse eligible for his/her employer-sponsored group health plan?

   ☐ Yes

   ☐ No (Letter from employer explaining why they are not eligible is required. Spouse will not be added if this is not provided.)

   ☐ My Spouse is self-employed, provide company name: _____

For any questions or concerns, contact EBD at 1-877-815-1017 or email Ask.EBD@arkansas.gov

By signing this affidavit I certify that the information provided above is accurate. I understand that any misrepresentations in the information I provided above will permit the ARBenefits Plan to terminate my coverage. If applicable, I authorize the release of the information noted above and agree to its use in the application process for ARBenefits Plan coverage.

Employee signature: _____ Date: _____

Spouse signature: _____ Date: _____

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:

Department of Shared Administrative Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-0983