KENT STATE UNIVERSITY
Division of Human Resources
Employee Benefits | P.O. Box 5190 | Kent, Ohio 44242-0001

Affidavit of Working Spouse/Domestic Partner Insurance Status

Kent State Employees - Complete Part I

A working spouse fee/domestic partner fee will be applied each pay for employees providing medical coverage to a spouse or domestic partner who is employed full-time, eligible for group health care coverage through their employer and elects not to enroll**.**

Please initial the box below that best describes your situation:

☐ Yes, my spouse/domestic partner has access to health coverage available through their employer and has elected not to enroll in their health plan. I am including my spouse/domestic partner on my Kent State health plan. I understand that the working spouse/domestic partner fee will be applied, and I authorize an automatic deduction from my paycheck on a pre-tax basis. **Sign below & continue to Page 2 Employer Verification.**

My Partner is _____ Full-time Employed

☐ Waive the fee. My spouse/domestic partner meets the following criteria (please check one):

_____Part-time Employed (Sign below & continue to Page 2 Employer Verification).

_____Retired _____Medicare Enrolled _____Self-Employed/Unemployed

_____Employed in a benefits eligible position at Kent State University

_____Employed, but does not qualify for or is not offered group health insurance

_____Employed, but in a non-Kent State medical plan as primary coverage, utilizing Kent State for secondary coverage.

If your partner is covered by your university-sponsored health plan, **the surcharge will be automatically deducted from your pay on a pre-tax basis. This affidavit must be submitted to the Employee Benefits office to request a fee waiver.** If eligibility is determined, the fee will be waived up to one pay period after submission. **Refunds will not be granted.**

I certify that the above information and election is true and correct to the best of my knowledge. I acknowledge that any false information made on this form as it relates to spousal and domestic partner health insurance eligibility may lead to disciplinary action. I also understand that Kent State will complete periodic audits and reserves the right to request supporting documentation to verify the representations I have made in this Affidavit. I also understand that if my spouse or domestic partner's group insurance status changes, it is my responsibility to notify the Employee Benefits Office within 31 days of such change.

_____ _____

Kent State Employee Name **(please print)** Kent State Identification Number

_____ _____

Kent State Employee Signature Date

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Employer of Working Spouse/Domestic Partner
Complete Part II

I, _____ (Spouse/Domestic Partner), authorize a representative of my employer, _____, to disclose the following information to the Kent State University Employee Benefits Office for the purpose of health insurance status verification.

Does the company provide health insurance benefits to employees? __Yes _No

The individual listed above is currently:

___ Enrolled in company-sponsored health insurance

___ On a waiting period, coverage will begin: _____

___ Eligible and has declined participation in our company-sponsored health insurance plan

___ Part-Time Employed

_____ _____
Company Name **(please print)** Date

_____ _____
Employer Representative Name **(please print)** Phone #

_____ _____
Employer Representative Signature Title/Position

_____
Employer Representative Email

Return completed form to Human Resources – Employee Benefits:
By email: benefits@kent.edu **| Fax:** 330-672-5447 **| In person**: 635 Loop Rd., Heer Hall

FOR BENEFITS ADMINISTRATION ONLY

Benefits Representative Signature _____ Date _____