City of Toledo
DEPARTMENT OF HUMAN RESOURCES

Spouse or Domestic Partner Work Verification Affidavit

Section A – To be completed by employee

Employee – print name _____ Phone Number _____

My spouse/domestic partner is: ☐Employed full-time ☐Employed part-time ☐Unemployed ☐Self-employed ☐Retired ☐Disabled

I UNDERSTAND THAT ANY FALSE DECLARATION, MATERIAL OMISSION OF INFORMATION, MISREPRESENTATION OR FALSIFICATION ON ENROLLMENT APPLICATIONS AND ANY AND ALL DOCUMENTS RELATED TO AND SUBMITTED FOR CITY OF TOLEDO BENEFITS COVERAGE MAY CONSTITUTE FRAUD AND MAY RESULT IN THE LOSS OF BENEFITS, LOSS OF COBRA CONTINUATION COVERAGE AND/OR LOSS OF DOMESTIC PARTNER CONTINUATION COVERAGE FOR MYSELF, ANY SPOUSE, DOMESTIC PARTNER, CHILDREN OR OTHER DEPENDENTS, MAY RESULT IN DISCIPLINARY ACTION, UP TO AND INCLUDING, TERMINATION OF EMPLOYMENT UNDER CITY OF TOLEDO POLICY, APPLICABLE LAW AND/OR COLLECTIVE BARGAINING AGREEMENT AND MAY RESULT IN THE CITY OF TOLEDO PURSUING CRIMINAL CHARGES AGAINST ME. I AGREE THAT THE CITY OF TOLEDO MAY RECOVER DAMAGES FOR ALL LOSSES INCLUDING, BUT NOT LIMITED TO, PAID CLAIMS, PREMIUM COSTS AND REASONABLE ATTORNEY FEES INCURRED.

I CERTIFY THAT THE INFORMATION PROVIDED IN ALL PARTS OF THIS APPLICATION IS TRUE, ACCURATE AND COMPLETE.

Signature of Employee _____ Date _____

Section B – To be completed by employee's spouse/domestic partner

I, _____ authorize my employer to release my healthcare plan coverage information and authorize the City of Toledo to determine my eligibility for health care coverage.

Signature of Spouse/Domestic Partner _____ Date _____

Section C – To be completed by spouse/domestic partner's employer

1. Is the person named as the spouse/domestic partner eligible for healthcare coverage?
   ☐No, please explain: _____
   STOP, please sign and date the form below.
   ☐Yes, please continue.

2. **Employee pays** _____% of the premium for EMPLOYEE ONLY and _____% of the premium for FAMILY coverage.

3. Employee contributes to a Health Savings Account (HSA).
   ☐No ☐Yes, please explain: _____

4. Employee's gross annual income is: ☐Less than $30,000 ☐Between $30,001 and $50,000 ☐Over $50,000

5. Does the employee receive a stipend or other incentive(s) or compensation to not enroll in your healthcare plan?
   ☐No ☐Yes, please explain: _____

6. Has the employee enrolled in the healthcare plan?
   ☐Yes, effective date: _____ Insurance Company: _____
   Coverage Type: ☐Employee Only ☐Employee +1 ☐Family
   ☐No, please indicate date coverage was waived or cancelled _____

Employer Name _____

Authorized Employer Name _____ Phone _____

Authorized Employer Signature _____ Title _____

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (ORC 3999.21)

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