Medical Plan – Spouse Eligibility Requirements
Attestation Form

Effective January 1, 2020, dependent spouses whose employer offers health insurance coverage and spouse is eligible for that coverage will no longer be eligible for coverage under Goodwill of NWNC's medical plan.

You are receiving this notice because your Spouse is currently covered on the medical plan or you have elected a coverage level that includes a Spouse.

To continue your spouse's coverage or enroll in new medical coverage, please complete this form in its entirety and return it via email to hrinfo@goodwillnwnc.org. Please note that if you plan to cover your Spouse on the medical plan and do not complete and submit this form, you will receive the appropriate level coverage.

1. ***Is your spouse employed?*** **Yes ☐ No ☐**
2. ***Does your spouse's employer offer health insurance?*** **Yes ☐ No ☐**

3. ***If you answered "Yes" to question #1, type the name and phone number of your spouse's employer:*** **Click or tap here to enter text.**

If you answered **"No" to *either question above*, you may continue to cover your spouse under Goodwill of NWNC's medical plan (you still need to complete and submit this form).**

If you answered **"Yes" to *both questions*, then your spouse will be removed from Goodwill's medical coverage effective January 1. 2024,** and your election tier will be adjusted accordingly. The loss in medical coverage should constitute a loss of coverage under HIPAA special enrollment rules and affected spouses should be able to enroll in coverage under their employer's plan. If this happens, your spouse would need to contact his or her employer to receive information as to how to enroll for medical coverage.

Please note that this only applies to Medical coverage, no other benefits are affected by this change.

If your spouse's employment situation or medical coverage eligibility changes during the year, it is your responsibility to notify Goodwill Human Resources within 30 days of the event.

Attestation Statement:
"I attest that the information I have provided on this form is true and accurate, and I understand that any false information or omission of information shall be sufficient reason (when/if it becomes known) for future medical benefit(s)/coverage to be cancelled for the remainder of the plan year."

4. **Please type your full name here: Click or tap here to enter text.**

5. ☐ I understand and agree that by checking this box constitutes my legal signature which confirms I understand the contents of this document and it also serves as legal signature for my attestation statement."