Vermilion Parish School Board
Instructions for Spousal Affidavit

All employees whose spouse is covered under the Vermilion Parish School Board Health Plan MUST complete this form.

If your spouse is eligible for health coverage from his/her employer and you elect to enroll him/her into the Vermilion Parish School Board health plan you will be required to pay a higher premium for your spouse.

Please read and complete the applicable Sections. Please note that Section C must be completed by your spouse's employer.

If there is any change in the status of your spouse's health coverage please contact Brandy Babineaux at 337-898-5844 or brandy.babineaux@vpsb.net within 31 days of the change.

Vermilion Parish School Board
Affidavit for Spousal Health Coverage

All employees whose spouse is covered under the Vermilion Parish School Board Health Plan MUST complete this form. If your spouse is currently enrolled or you are newly enrolling your spouse in our health plan and you fail to return this form you will be automatically assessed the higher monthly premium.

Employee: _____ Employee Payroll #: _____

Name of Spouse: _____

SECTION A: (To be completed by Employee)

1. Is your spouse employed? ☐ Yes ☐ No
   If no, please circle one: Retired Disabled Unemployed Other: _____
2. Is your spouse self-employed? ☐ Yes ☐ No
   If yes, please provide: Company Name: _____ Phone #: _____

If the answer is "Yes", please date and sign Section B and returned to the insurance department.
If "No", please continue to question 3.

3. Is your spouse offered health insurance by his/her employer? ☐Yes ☐No
4. If yes, is your spouse enrolled? ☐Yes ☐No

Please date and sign Section B and have your spouse's employer fill out Section C.

SECTION B: (To be completed by Employee)

I understand that if my spouse is not eligible for employer-sponsored health insurance at this time but would become eligible for employer-provided health coverage at a later date I will promptly notify the insurance department. The insurance department must be contacted within 31 days of the change.

Please note that providing false information on this document will subject the employee to disciplinary action up to and including termination and may be subject to repayment of benefits or premiums paid on behalf of the spouse and/or loss of coverage.

_____ _____ _____
Signature Print Name Date

SECTION C: (To be completed by Spouse's Employer)

Please complete the section below regarding your employee's access to employer-sponsored group health coverage.

Do you offer coverage to your employees? ☐ Yes ☐ No
Is the Spouse referenced above offered Employer Sponsored Group Health insurance? ☐ Yes ☐ No
If yes, is the employee enrolled? ☐ Yes ☐No
If not, please circle reason: Part-time employee New Hire waiting period Other: _____

_____
Name of Employer Address Phone Number

_____
Employer Representative Signature Printed Name Title Date

Return the complete form to:
Vermilion Parish School Board
Attn: Brandy Babineaux
PO Box 520
Abbeville LA 70511