INDIANA UNIVERSITY

IU-Sponsored Health Care Plans
AFFIDAVIT OF ELIGIBLE SPOUSE/CHILD STATUS

Instructions: This form is to be used in cases where the employee does not have possession of or access to any document that verifies a marriage or birth relationship to the employee, for example: when actual source documents have been destroyed by fire or other disaster. Unless there are extenuating circumstances, the University would not consider documents inaccessible when they are available through public agencies such as the courts or through a state health department.

Employee Name: _____
First Middle Last

Social Security Number _____ / _____ / _____

I attest that I do not have documentation in my possession, at home or elsewhere, to verify my marriage to the following individual; and that the individual listed below is my spouse as recognized by a legally binding marriage as defined by Indiana law or as certified by the government in the foreign country of my marriage; and that this marriage has not been ended by divorce.

Spouse/Child Full Legal Name	Social Security Number*	Date of Birth
	/ /	/ /
	/ /	/ /

* If your spouse is a foreign national who is not eligible for a Social Security Number due to a non-working visa, list their ITIN number. If they do not yet have an ITIN number, write the visa type (J2, F2, or H4) in the box to indicate that this person is not eligible for a Social Security Number. Report your spouse's ITIN number to Human Resources as soon as it is available.

U.S. State or Foreign Country in which the marriage was performed: _____

Is the marriage a *legally* recognized marriage in this State or Country: _____

The institution or entity that performed the marriage: _____

Documentation to verify the marriage or birth relationship of the above individuals to the employee is not available for the following reason:

_____

_____

_____

***** All of the above information is required for processing this affidavit. *****

Employee Certification:

By signing this form you are certifying that:

- you have read and understand the University's health plan eligibility guidelines;
- that the above listed spouse is your legal spouse as defined by the State of Indiana or by the government of the foreign country in which the marriage took place, and has not been ended by divorce;
- that the information supplied on this form is true and complete and that any false information or statements made on this form will be grounds for IU to void your coverage and/or terminate your employment;
- you understand your responsibility to notify the University in writing within 60 days of a divorce from your spouse (a spouse is ineligible for health plan coverage as of the date of the divorce); likewise provide notice that a child is no longer your dependent.
- you understand that enrolling an individual that is not your legal spouse/child or failing to provide notice of ineligibility can result in retroactive termination of health care coverage for you and the enrolled spouse (coverage will end on the date the spouse or child was no longer eligible regardless of when notice was given to the University); and
- that such retroactive termination will result in liability on your part for any claim or premium costs paid by the health Plan retroactive to the date the individual was ineligible for coverage.

Employee signature_____Date:_____