Spousal Healthcare Affidavit

(Required only if you wish to cover your spouse/partner under Hankin Group's healthcare program)

Name of Employee: _____

Name of Spouse/Partner: _____

***Important*: If you are a Hankin Group employee who has selected medical coverage for your spouse/partner, you must complete this form and submit it via the task you are assigned in Employee Navigator. If applicable, you must also submit any required information outlined below. Be sure to complete this form accurately and in full. Your response, or lack of response, will impact the availability of medical coverage for your spouse/partner.**

SECTION I – Spouse Employment/Coverage Information

If your spouse/partner is eligible for quality[1] and affordable[2] coverage elsewhere (such as through their employer, Medicare, military/veterans' benefits, etc.), then they are *not eligible for Hankin Group healthcare coverage*. If this applies and you have elected to cover your spouse/partner, there is no need to submit this form. Rather, please return to Employee Navigator and remove your spouse/partner from your medical plan election. Contact Human Resources with any questions.

If your spouse/partner is not eligible for quality[1] and affordable[2] coverage elsewhere, select one of the following:

- ☐ Unemployed or ineligible for other coverage (*eligible for Hankin Group coverage*)
- ☐ Also employed at Hankin (*eligible for Hankin Group coverage*)
- ☐ Eligible for other coverage, but it does not meet the minimum quality[1] or affordability[2] standards (***may be eligible for Hankin Group coverage[3]***)

[1] Quality means the plan provides coverage at or above a Silver metal rating, or the equivalent thereof, based upon the established government quality standards. If you have any questions on whether other coverage can be considered "quality," please provide Human Resources with all available benefit details for the coverage in question.

[2] Affordable means the cost of the other available coverage does not exceed 4% of the Hankin Group employee's gross wages. If you have any questions on whether other coverage is "affordable," please provide Human Resources with all available cost share information.

[3] If you select this option, you must provide Human Resources with all applicable coverage and/or cost share information.

SECTION II – Employee Attestation

I certify that the foregoing is true, correct, and current. I understand as an employee that willful falsification of information on this Affidavit may lead to disciplinary action. I further acknowledge that it is my responsibility to notify the Hankin Group Office of Human Resources if, at any future date, the information provided above changes.

Please note that Hankin Group reserves the right to request information to verify the stated criteria are met. In the event the supporting documents do not meet the stated criteria, the company reserves the right to deny coverage under Hankin Group's medical plan.

Employee Signature: _____ Date: _____

Please submit this form via the Employee Navigator task you have been assigned. Contact Carolyn Van Fleet at carolyn.vanfleet@hankingroup.com or 610-453-1900 with any questions.