HALO HEALTH PLAN
SPOUSAL CARVE-OUT AFFIDAVIT

The HALO Medical Plan will no longer allow spouses on the plan if your spouse is eligible for coverage through their employer and their employer pays at least 50% of the cost.

In order to enroll your spouse in the HALO Medical Plan, you must complete and return this Spousal Carve-out Affidavit with your Enrollment Form, indicating which of the following applies:

- ☐ My spouse **IS NOT EMPLOYED**.
- ☐ My spouse **IS EMPLOYED AT HALO**. (Carve-out will not apply)
- ☐ My spouse is self-employed or employed at a workplace other than HALO but **IS NOT OFFERED OR ELIGIBLE FOR** employer sponsored group health benefits.
- ☐ My spouse is employed at a workplace other than HALO and **their employer contributes less than 50% of the cost of their medical coverage.**
- ☐ My spouse is employed at a workplace other than HALO and **their employers pays at least 50% of the cost of medical coverage.**

If your spouse loses or obtains health coverage through an employer, you have 31 days to notify the Human Resource Department of such change. The Human Resource Department needs to be notified in writing of this and all Family Status changes within 31 days of when the change occurred. Failure to notify the Human Resource Department in a timely manner will bar you from making a change until the next annual open enrollment period.

Employee Acknowledgement

My signature below indicates that the facts set forth on this form are true and complete to the best of my knowledge. I also understand that if my spouse's group health insurance status changes, it is my responsibility to notify the Human Resource Department in writing within 31 days of such change. Any false statements written on this form or on future forms as it relates to spousal health information shall be considered grounds for disciplinary action and/or rescission of coverage.

Your Name:	**Spouse's Name:**
Date:	**Spouse's Employer:**
Your Signature:	**Spouse's Employer Group Medical Plan Name:**
Spouse's signature:	**Spouse's Employer Group Medical Plan Number:**

Employer Acknowledgment

Reviewed By:	**Action Taken:**	**Date:**