



Office of Benefits Administration  
Human Resources  
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**2023 Working Spouse Form for Primary Coverage Certification**

**Who must complete this form?** **Employee electing** medical or dental coverage for their spouse.  
**When must this form be completed?** Annually during each open enrollment period and within 31 days of qualifying event.

**UA Employee Name (print):** \_\_\_\_\_ **Employee ID #:** \_\_\_\_\_

**Spouse Name (print):** \_\_\_\_\_ **Spouse SSN:** \_\_\_\_\_

**Section A - My Spouse is (check one):**

Employed Part Time (*Employer MUST complete Section B.*)  Employed Full Time (*Employer MUST complete Section B.*)

Not Employed  Self-Employed  Retired  Full-time UA Employee

I wish to elect **secondary coverage** for my spouse through UA. (Please sign below and return to Benefits Administration with a copy of your spouse’s primary insurance card.)

*If my spouse’s employment or health insurance coverage status changes in the future, I understand that I am responsible for contacting Benefits and completing the appropriate paperwork within 31 days of the change. I certify the above completed information is true and correct to the best of my knowledge and understand that any misstatement constitutes fraud and may result in termination of benefits and/or employment.*

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

*I, as the spouse of a UA employee, authorize the release of the medical plan coverage information set forth in Section B and authorize its use in making application for UA health insurance.*

Spouse Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section B – Employer Certification**

1. Is the above-named spouse eligible for your group medical health insurance?  Yes  No
2. Is the above-named spouse required to pay 50% or less of your total plan premium?  Yes  No  
**If yes, the named spouse is NOT eligible for primary coverage under UA’s health plan and must enroll in your plan.**  
**If no, the named spouse is eligible for coverage under UA’s health plan.**
3. If not already enrolled, when will the named spouse’s health coverage with you begin? \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name and Title of Individual Completing the Form \_\_\_\_\_

Employer Name and Address \_\_\_\_\_

Employer Phone Number and/or Email \_\_\_\_\_

**The above responses are correct to the best of my knowledge.**

\_\_\_\_\_  
Signature of Employer Representative

\_\_\_\_\_  
Date