WINSTON SALEM INDUSTRIES FOR THE BLIND, INC.
EMPLOYER HEALTH PLAN SPOUSAL AFFIDAVIT

This form is required to be completed in full when an employee is enrolling in spouse (or seeking to continue enrollment of a spouse) in health care coverage under Winston Salem Industries for the Blind, Inc. Health and Welfare Plan (the Plan). **No spouse will be eligible or be enrolled in health coverage under the Plan until this form is completed and returned to Human Resources.**

This change went into effect July 1, 2013. Your spouse will not receive health care coverage under the Plan unless he or she is eligible under one of the options set forth below and you return this Affidavit to Human Resources.

TO BE COMPLETED BY EMPLOYEE

Employee Name (please print): _____

Spouse Name (please print): _____

A spouse of an eligible employee plan participant may only enroll in health care coverage under the Plan if one of the following conditions is met.

Please check and/or complete the appropriate option:

☐ My spouse is not employer or self-employed.

☐ My spouse is employed by _____ but is not offered or eligible for health care coverage from his or her employer.

☐ My spouse works for Winston Salem Industries for the Blind, Inc. in a full-time classified position that is eligible for coverage by the Plan.

I attest that all information above is true and correct to the best of my knowledge.

- *I understand that falsification of information regarding my spouse's available coverage constitutes fraud or intentional material misrepresentation and will result in disciplinary action against me, and my result in termination of my employment.*
- *I understand that if the status of my spouse's eligibility for health care coverage changes, it is my responsibility to notify Winston Salem Industries for the Blind, Inc. Human Resources within 30 days of the change and failure to do so may result in termination or rescission of my health care coverage under the Plan.*
- *I understand that medical claims may be denied for my spouse who was enrolled or continued participation in health care coverage under the Plan under false representations, and my spouse or I may be liable to repay benefits under the Plan paid to or for my spouse during any period for which my spouse was enrolled under false representations.*

Employee Signature: _____ Date: _____