# Spouse: Employer Declaration Form

SAG·AFTRA HEALTH PLAN

## Instructions

First have your spouse's employer complete this form. Then provide your identifying information below BEFORE submitting the form.

PARTICIPANT HCID/SSN

PARTICIPANT NAME

CONFIRMATION # FROM COTIVITI WEBSITE (optional)

**HOW TO SUBMIT THIS FORM**

Scan and email a copy of your completed form to:
SAGAFTRAHPForms@Cotiviti.com

**Or**

Mail your completed form to:
Cotiviti
P.O. Box 543099
Omaha, NE 68154

## Employer Information (To be completed by your Spouse's employer)

| EMPLOYEE'S FIRST AND LAST NAME | | | | DATE OF BIRTH |
|---|---|---|---|---|
| EMPLOYER'S NAME | | | | |
| MAILING ADDRESS | CITY | STATE | ZIP CODE | PHONE NUMBER ( ) |

| | |
|---|---|
| **Do you offer Employer Group Health Coverage to this employee?** | ☐ NO — Sign and return original form to employee<br>☐ YES — Select one: ☐ Active Policy ☐ Retiree Policy |
| **Is the employee enrolled in the company's Group Health Insurance?** | ☐ NO — New hire, waiting for period end date: _____<br>☐ YES — Provide Group Plan information below |
| **For what type of coverages are they enrolled?** | ☐ Medical/Hospital ☐ Rx ☐ Dental ☐ Vision<br>☐ Mental Health |
| **Are any family members enrolled under the coverage?** | ☐ NO — Sign and return original form to employee<br>☐ YES — Add details for enrolled family members below |

| LAST NAME | FIRST NAME | MI | DATE OF BIRTH | LAST NAME | FIRST NAME | MI | DATE OF BIRTH |
|---|---|---|---|---|---|---|---|
| LAST NAME | FIRST NAME | MI | DATE OF BIRTH | LAST NAME | FIRST NAME | MI | DATE OF BIRTH |
| LAST NAME | FIRST NAME | MI | DATE OF BIRTH | LAST NAME | FIRST NAME | MI | DATE OF BIRTH |

| GROUP HEALTH PLAN NAME | POLICY NAME | GROUP NUMBER | PHONE NUMBER ( ) |
|---|---|---|---|

I certify under penalty of perjury that to the best of my knowledge all information provided on this document is true, correct and complete. I acknowledge that it is fraudulent to knowingly fill out this form with any information that is false.

AUTHORIZED EMPLOYER SIGNATURE | TITLE | TELEPHONE/EXT | DATE

**Questions?** Please call us at 877-795-4611.