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 ☐ YES — Select one: ☐ Active Policy ☐ Retiree Policy
Is the employee enrolled in the company's Group Health Insurance?	☐ NO — Next Enrollment Date: _____ Effective Date: _____ ☐ YES — Enrollment Date: _____ Effective Date: _____
For what type of coverages are they enrolled?	☐ Medical/Hospital ☐ Rx ☐ Dental ☐ Vision ☐ Mental Health
Are any family members enrolled under the coverage?	☐ NO — Sign and return original form to employee ☐ 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.