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MEMORANDUM

TO: ALL EMPLOYEES WITH HEALTH INSURANCE
FROM: GENE SMITH & PATTY ISAACSON
SUBJECT: **CERTIFICATION OF COVERAGE**
HEALTH INSURANCE – SPOUSE & DEPENDENT COVERAGE
DATE: SEPTEMBER 30, 2014

If you have a dependent (spouse and/or children) on your health insurance plan, you must complete this form and return with the Preferred One Member Enrollment Form to your Payroll Center.

Note: failure to complete and return this form will be construed as an indication that your spouse and/or dependent(s) are eligible and have affordable health care insurance available to them and you will be charged 50% of the premium through a payroll deduction.

HOW TO USE THIS FORM

This form has two sections.

- Section I can be used to help you determine if your spouse and/or child has affordable health care available.
- Section II will certify to Dunn County whether or not your spouse and/or dependent(s) qualify for health insurance coverage.

Section I

Determining Whether Or Not Your Spouse and/or Children Are Eligible to stay on your health insurance plan without additional costs.

The following list should not be used as the sole determination on if your spouse and/or dependents are eligible for affordable health insurance through their employer. Consult with dependent's employer as they should know health benefits available to their employees.

In general, ask dependent's employer the following questions:

- Do you offer affordable health insurance according to the Affordable Care Act rules and guidelines?
- Am I eligible to participate in this affordable health insurance at the affordable cost?
- Is the affordable health plan a standard or high deductible (HSA/HRS) eligible plan?

Section II
Certification of Coverage

Complete the following information below for each dependent (spouse and/or children) on your health plan to declare whether or not they qualify to stay on your health insurance plan at no additional cost.

Regarding _____ (dependent name) - I certify that: (Circle all responses that apply)

- This dependent has health insurance available through their employer. (**yes** / **no**)
- Their health insurance is affordable within the definitions of the Affordable Care Act. (**yes** / **no**) - See Section 1
- This dependent (**is** / **is not**) currently participating in an affordable health insurance plan offered by their employer.
- This dependent (**will** / **will not**) be enrolling in their employers affordable health care plan at the next available opportunity expected to be effective _____, 20____.

Regarding _____ (dependent name) - I certify that: (Circle all responses that apply)

- This dependent has health insurance available through their employer. (**yes** / **no**)
- Their health insurance is affordable within the definitions of the Affordable Care Act. (**yes** / **no**) - See Section 1
- This dependent (**is** / **is not**) currently participating in an affordable health insurance plan offered by their employer.
- This dependent (**will** / **will not**) be enrolling in their employers affordable health care plan at the next available opportunity expected to be effective _____, 20____.

Regarding _____ (dependent name) - I certify that: (Circle all responses that apply)

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Regarding _____ (dependent name) - I certify that: (Circle all responses that apply)

- This dependent has health insurance available through their employer. (**yes** / **no**)
- Their health insurance is affordable within the definitions of the Affordable Care Act. (**yes** / **no**) - See Section 1
- This dependent (**is** / **is not**) currently participating in an affordable health insurance plan offered by their employer.
- This dependent (**will** / **will not**) be enrolling in their employers affordable health care plan at the next available opportunity expected to be effective _____, 20____.

Dunn County employees who have insured dependents who have chosen to not utilize affordable health care opportunities available to them through other employers will be responsible for a 50% share of the applicable premium.

Employee Signature

Date

Printed Name & Department