AFFADAVIT OF SPOUSE HEALTH CARE COVERAGE

PLEASE ENSURE THIS FORM IS FULLY COMPLETED. YOUR RESPONSE, OR LACK OF RESPONSE, WILL IMPACT YOUR SPOUSE'S HEALTH CARE COVERAGE.

CLOCK NUMBER	PRINTED NAME OF EMPLOYEE

All spouses of the Spitzer plan who are eligible for medical coverage under the group health plan of another employer and choose to elect Spitzer Industries coverage will be subject to a bi-weekly surcharge of $23.08. If your spouse does not have other medical coverage available, your spouse will be allowed to enroll in the plan at the regular applicable premium rate.

You must, however, complete the information listed below and return this form to Human Resources to certify that other medical coverage is not available to your spouse. If there is a change in your spouse's coverage representing a HIPAA special enrollment period, you must notify Spitzer Industries within 31 days of the change.

Section 1: Spouse Employment Information

NOTE: This section must be completed

Is your spouse currently employed? (Please check only one box.)

- ☐ Yes employed, and offered group coverage (Surcharge) (Sign below – Continue to Section II)
- ☐ Yes employed, and NOT offered group coverage (No Surcharge) (Sign below – Continue to Section II)
- ☐ Self-employed and offered group coverage (Surcharge) (Sign below – Section II not required)
- ☐ Self-employed and not offered group coverage (No Surcharge) (Sign below – Section II not required)
- ☐ Not employed/Retired (No Surcharge) (Sign below – Section II not required)
- ☐ Also an employee of Spitzer Industries (No Surcharge) (Sign below – Section II not required)

I certify, under penalty of perjury, that the foregoing and following is true, correct and current. I understand as an employee of Spitzer Industries , willful falsification of information on this affidavit may lead to disciplinary action.

EMPLOYEE SIGNATURE	DATE

Section 2: Employer Certification of Spouse Health Benefit Coverage

NAME OF SPOUSE	EMPLOYER OF SPOUSE