Catholic Health Services
of Long Island
At the heart of health

## Catholic Health Services Spouse Coverage Attestation

You are receiving this document as part of the 2019 Open Enrollment process. According to your 2019 Open Enrollment Benefits election, you elected the Medical Select Plan option and chose to enroll your spouse as a dependent.

**An eligibility requirement for an employee's spouse to be enrolled in the Select Plan is that the employee's spouse does not have an offer of coverage through his/her own employer**. If your spouse is not working and/or is eligible or enrolled in coverage through Medicare, your spouse is eligible for coverage under the Select Plan.

Please read the statement below and take either of the following actions **no later than December 1st 2018**:

- **If the below statement is TRUE** for your circumstances, please sign below, and return this document to the Catholic Health Services (CHS) MyHR team via email (MyHR@chsli.org), mail (3 Huntington Quadrangle Suite 301S Melville, NY 11747), or fax (516-705-2828) no later than December 1st, 2018.
- **If the below statement is NOT TRUE**, please reach out to the CHS MyHR team at 516-705-MyHR (6947) no later than December 1st, 2018. You will need to change your medical plan enrollment for 2019 by either removing your spouse from the Medical Select Plan, or choosing another Medical Plan option to keep your spouse as an enrolled dependent under your medical coverage.

If MyHR does not hear from you by December 1st 2018, we will assume that your spouse has access to coverage through his/her employer and will remove your spouse from coverage effective January 1st 2019.

## STATEMENT

I _____, am attesting that my spouse, _____
[Enter your name] [Enter your spouse's name]
does not have access to coverage through his/her own employer. If my spouse gains access to coverage through his/her employer, I understand that he/she is no longer eligible for coverage under the Catholic Health Services Select Plan and it is my responsibility to reach out to the Catholic Health Services MyHR team within 31 days so that I may update my enrollment accordingly.

By signing this document below, I am agreeing that I have read and understand these eligibility requirements, and attest that my spouse meets these eligibility requirements. I further attest that all information I have provided in connection with my application for benefits under the Plan is true and accurate.

_____ _____
[Sign your name] [Date]

_____ _____
[Print your name] [Employee ID Number]