Non Union

Affidavit of Medical Coverage for Spouse

Name of JBS/Pilgrim's Employee: _____ **Employee ID:** _____

Name of Spouse: _____

Important: please ensure this form is FULLY COMPLETED.
Your response, or lack of response, will impact your spouse's medical coverage.
Failure to provide a completed form will result in denial of your spouse's medical coverage.

SECTION I: Spouse Employment Information

1. Is your spouse currently employed?

□ Yes (sign below, continue to Section II)

□ Self-employed (sign below, continue to Section II)

□ Not employed / Retired (sign below, skip Section II)

2. Is your spouse also an employee of JBS or Pilgrim's? □ Yes □ No

If yes, please provide spouse's employee ID: _____

If your spouse is eligible for medical benefits from his/her own employer, your spouse is **not eligible to enroll in medical coverage** through JBS USA Food Company / Pilgrim's Pride.

I certify and warrant to JBS USA Food Company / Pilgrim's Pride that all information on this form is true, correct and current. I understand as an employee that falsification of information on this Affidavit may lead to termination of coverage and disciplinary action, up to and including termination of employment.

_____ _____

Employee Signature *(required)* Date

SECTION II: Employer Certification of Spouse Health Benefit Coverage

*NOTE: this section must be completed in full by **your spouse's employer***

Name of Spouse: _____

1. Is the spouse above an employee of your company? □ Yes □ No

2. Is the spouse named above eligible for medical benefits through your company? □ Yes □ No

3. If so, is the spouse enrolled in medical coverage? □Yes □ No

4. If not enrolled but eligible for medical coverage, when can the spouse enroll in the plan? _____

Additional information/comments regarding the above: _____

Name of employer: _____

Name of Representative (Printed):_____ **Phone:** (___) _____

Signature of Representative: _____

Title: _____ **Date:** _____