Affidavit of Medical Coverage for Spouse/Domestic Partner

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

Name of Spouse/Domestic Partner: _____

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

SECTION I: Spouse/Domestic Partner Employment Information

1. Is your spouse/domestic partner 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/domestic partner also an employee of JBS or Pilgrim's? □ Yes □ No

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

If your spouse/domestic partner is eligible for medical benefits from his/her own employer and your spouse/domestic partner is enrolled in your coverage through JBS USA Food Company/Pilgrim's Pride, an **annual surcharge of $600 will apply.**

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/Domestic Partner Health Benefit Coverage

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

Name of Spouse/Domestic Partner: _____

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

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

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

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

Additional information/comments regarding the above: _____

Name of employer: _____

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

Signature of Representative: _____

Title: _____ **Date:** _____