

WORKING SPOUSE ATTESTATION

Required only when the spouse is employed or self-employed

If you are covering a spouse who is employed or self-employed, this attestation is required to complete spousal verification. Complete and sign **Section 1**. Your spouse signs **Section 2**. Your spouse's employer completes **Section 3**. If your spouse is self-employed, your spouse completes both Sections 2 and 3.

DEADLINE AND SUBMISSION

Submit the completed attestation by the deadline shown in the notice you received. If complete and acceptable verification is not received by that deadline, spouse coverage will be terminated retroactively.

SECTION 1 | TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE NAME	SPOUSE NAME
EMPLOYEE PHONE	CASE REFERENCE (IF ASSIGNED)

I certify the information on this attestation is true, correct, and current. I understand knowingly providing false, incomplete, or misleading information may result in denial or termination of benefits and other penalties. I authorize my employer and its representatives to verify the facts provided and to contact appropriate organizations for that limited purpose.

EMPLOYEE SIGNATURE	DATE
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SECTION 2 | TO BE COMPLETED BY THE SPOUSE

I authorize the use or disclosure of the information requested on this attestation to verify my eligibility for medical coverage. This authorization is limited to the verification process and expires at the end of the applicable plan year.

SPOUSE SIGNATURE	DATE
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SECTION 3 | TO BE COMPLETED BY THE SPOUSE'S EMPLOYER

Is the spouse named above eligible for medical coverage through your organization?

☐ Yes ☐ No

COMPANY / BUSINESS NAME	
REPRESENTATIVE PRINTED NAME	REPRESENTATIVE TITLE
REPRESENTATIVE SIGNATURE	SIGNATURE DATE
CONTACT PHONE NUMBER	CONTACT EMAIL ADDRESS

HOW TO SUBMIT Upload the completed attestation securely at <https://myescbenefits.com/verify>

Only scanned original signatures or certified digital signatures will be accepted.

QUESTIONS LCSC Benefits Help Desk (440) 644-3093