HAMPSHIRE COUNTY GROUP INSURANCE TRUST

Subscriber Affidavit of Marital Status

Please print

Subscriber Name: _____

Address: _____ _____

Town/City: _____ State: _____ Zip Code: _____

Best Contact Number: _____

Email Address: _____

Dependent Spouse or Former Spouse:

Name: _____ Date of Birth: _____

Address (If different than above): _____

Are you currently legally married to this dependent? YES / NO

If **YES**, attach a photocopy of the City/Town Clerk's marriage certificate.

If **NO**, attach a copy of signature page of divorce and page relating to health insurance provision.

Are you remarried? NO / YES

If Yes, Date of remarriage: _____

Is your former spouse remarried? YES / NO / Unknown

If YES, Date of marriage: _____

Please initial each after reading:

_____I hereby certify that the information provided above is true and accurate.

_____I understand that I am obligated to inform my employer immediately if there are any changes in my status or that of my spouse/ex-spouse.

_____ I understand that should I or my ex-spouse remarry, my ex-spouse may not continue on my coverage beyond the date of marriage except by court order and must be enrolled in individual coverage for which I will be responsible for 100% of the cost.

_____ I understand that any misrepresentation in the information given may result in termination of benefit eligibility for myself and/or my spouse/ex-spouse.

_____ _____

Subscriber Signature Date