HAMPSHIRE COUNTY GROUP INSURANCE TRUST

Subscriber Affidavit of Marital Status

(Please print)

Employee:

Subscriber Name: _____

Address: _____ _____

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

Best Contact Phone Number: _____

Spouse or Former Spouse:

Name: _____ Date of Birth: _____

Address (If different than above): _____

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

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

If **NO**, attach a copy of the divorce decree including the first page, the signature page, and all pages relating to health insurance provision. Answer the following questions:

Are you remarried? YES / NO

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, including divorce or any remarriage.

_____ I understand that should I or my ex-spouse remarry, my ex-spouse may NOT continue on my coverage beyond the date of remarriage, and I must notify my employer immediately to process a cancellation at such time.

_____ I understand that any misrepresentation in the information given above or failure to provide appropriate timely updates on any status changes may result in termination of benefit eligibility for myself and/or my spouse/ex-spouse.

_____ _____

Subscriber Signature Date