Louisiana Assessors' Association (LAA) PLAN YEAR 2024

Working Spouse Verification Form

To be completed by employees with spouses on the LAA Plan

HOW TO SUBMIT THIS FORM

Email to pat@louisianaassessors.org

Or

Fax to: 225-928-4677

Spouse

LAST NAME	FIRST NAME	DATE OF BIRTH	

EMPLOYMENT STATUS

- ☐ Employed – Complete Sections 1, 2, & 3
- ☐ Employed -Not Offered Insurance Benefits
- ☐ Self-Employed – Skip to Section 3 (LAA PRIMARY)
- ☐ Retired – Primary Coverage with _____
- ☐ Not Employed — Skip to section 3 (LAA PRIMARY)

Section 1. Employer Information

EMPLOYER'S NAME

MAILING ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER

Section 2: Does the employer offer health insurance (medical, hospital and prescription drug coverage)?

Select one of the following:

- ○ Spouse has chosen not to enroll on their employer's health insurance and become primary with LAA.
- ○ Spouse is a new hire and waiting to start their employer's health insurance. Waiting period end date _____
- ○ Spouse is covered by their employer's health insurance as primary. Please provide details below:

POLICY TYPE	HEALTH PLAN NAME
☒ Group (through employer)	

POLICY NUMBER	PHONE NUMBER	EFFECTIVE DATE

TYPE OF COVERAGE

☐ Medical/Hospital ☐ Rx ☐ Dental ☐ Vision

Section 3: Declaration Statement

I confirm that the details provided are truthful and accurate. I understand that I must notify the Health Plan as soon as possible and at least within 30 days of any changes to my spouse's entitlement to coverage offered through their employer. I understand that as part of the Plan's periodic audit process, I may be asked to provide additional documentation supporting these statements and that if the Plan determines my spouse was not eligible for coverage, I may be responsible for reimbursing the Plan for any benefit costs incurred during the time my spouse was ineligible.

SIGNATURE OF MEMBER PRINT NAME PARISH DATE