Affidavit of Marriage

To enroll your spouse in any of the Santa Clara University sponsored health and welfare plans, please complete this form and submit it, along with your Enrollment Application(s), to the Department of Human Resources.

This form must be submitted during open enrollment *or* within thirty (30) days of establishing or terminating your marriage.

Because we require the social security number, ***please do not submit via email***.

Employee Name:____

Spouse Social Security Number:____________________________________

Address:____

City: ______________________State__________Zip________________

Name of Spouse:________________________________

We declare that we have a validly issued marriage certificate issued in the state of

California or another jurisdiction, and certify the following:

- ❑ We possess a current and valid marriage certificate recognized by the state in which we were married.
- ❑ We have met the requirements of the state agency who issued the marriage certificate
- ❑ We were capable of consenting to the marriage

We understand that Santa Clara University reserves the right to request a copy of our marriage certificate.

We provide the information in this affidavit to be used by the University for the sole purpose of determining Health and Welfare benefit eligibility for my spouse.

We understand that spouses are subject to the same window period governing all other employees who are covered by or applying for benefit plan coverage. Any children, new employees, adoptions, new marriages, and registered domestic partnerships are subject to a thirty (30) day limit on the enrollment period from the date of eligibility.

We agree to notify the Department of Human Resources within thirty (30) days of the termination of our marriage. Proof of termination of the marriage shall be provided to the Human Resources Benefits Office

We affirm, under the penalty of perjury, that the assertions in this Affidavit are true and accurate to the best of our knowledge. We understand that willful falsification of information contained in this Affidavit may result in our termination of enrollment by the plan providers which we have selected for coverage.

______________________________		______________________________		
Signature of employee	Date	(Last)	(First)	(Middle)
______________________________		______________________________		
Signature of spouse	Date	(Last)	(First)	(Middle)

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Date of Marriage