MOHAWK INDUSTRIES, INC.

Mohawk Industries Health Care Plan
Spousal Healthcare Eligibility Affidavit

alight

Employee Name _____ Reference Number _____

Spouse Name _____ Gender_____ Last four of SSN _____

Section A: *Must be completed if "Spouse" is enrolled in the Mohawk Industries Health Care Plan.*

#1___ Spouse is not employed OR is eligible for Medicare OR is a US Veteran OR works at Mohawk Industries OR is enrolled in dental and/or vision only **(DO NOT NEED TO COMPLETE SECTION B)**

Works at Mohawk ___Not employed___ Eligible for Medicare___ US Veteran___ Dental/Vision only____

#2___ Spouse is employed **WITHOUT** access to medical coverage from his/her employer OR spouse is self-employed without access **(SPOUSE'S EMPLOYER MUST COMPLETE SECTION B)**

#3___ Spouse is employed **WITH** access to medical coverage at their current place of work **(SPOUSE'S EMPLOYER MUST COMPLETE SECTION B)**

NOTE: ***If your spouse is eligible for medical coverage at their current job and you enroll your spouse in Mohawk's coverage, you will have to pay a spousal surcharge of $125 for employees paid on a monthly pay cycle and $28.85 for employees paid on a weekly pay cycle. If a completed Spousal Affidavit is not submitted, spouse coverage type will default to #3 and the spousal surcharge will be automatically applied for all eligible spouses. ****

I hereby certify that the information provided above is correct. I understand that any misrepresentation in the information I have provided above will permit Mohawk Industries to terminate my spouse's coverage and seek any other legal remedies available including possible prosecution for insurance fraud. If applicable, I authorize the release of the health care plan coverage information requested below and authorize its use in accepting the application for the Mohawk Industries Health Care Plan.

Employee Signature _____ Date _____

Spouse Signature _____ Date _____

Section B: *Must be completed by **spouse's employer** if Section A is **#2** or **#3**. Section B may be completed by the spouse, **only** if the spouse is self-employed.*

Does the spouse named above have access to health coverage at his/her job? __YES __ NO

Spouse's Employer_____

Spouse's Employer Address _____

Spouse's Employer Phone Number _____

Authorized Employer Name _____ Title_____

Authorized Employer Signature _____ Date_____

*Submit this completed document to Alight Solutions **with all other necessary documentation** (see attached Matrix).*
**(Spouses may be subject to other charges and fees. It may take up to 60 days for processing and removal of the surcharge. For more information, go to www.mymohawkbenefits.com.)*

FAX TOLL FREE TO: 1-888-205-0425
or EMAIL TO: mohawkind-mail@depconfirm.com