2025 Working Spouse Affidavit

(For medical and prescription coverage)

Important: Please ensure this form is fully completed. Your response, or lack of response, will impact your spouse's medical coverage.

This Form Consists of Four Parts	
☐ **Part One**	Please complete with your name, Social Security Number and Employee ID Number and name of your spouse.
☐ **Part Two**	Please complete to certify and declare that your spouse is eligible for coverage under the Southern Glazer's Wine & Spirits, LLC Employee Benefit Plan.
☐ **Part Three**	Please have your spouse's employer complete to certify and declare they are not eligible for or enrolled in their medical plan.
☐ **Part Four**	**Return this form by mail to SG Connect People Center**, 14911 Quorum Drive, Suite 150, Dallas, TX 75254, or by email to **peoplecenter@sgws.com**.

If your spouse is eligible for group medical coverage through his or her employer, your spouse will be disqualified from receiving any benefits under the Southern Glazer's Wine and Spirits, LLC medical plans.

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EMPLOYEE INFORMATION (please print)

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER

NAME OF SPOUSE

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SPOUSE EMPLOYMENT INFORMATION (this section must be completed by the Employee*)

Is your spouse currently employed? (select one of the options below)

- ☐ A. Yes, but he/she **is not** offered major medical/prescription coverage
- ☐ B. Yes, and he/she is offered major medical/prescription coverage
- ☐ C. Yes, and he/she is self-employed
- ☐ D. No, he/she is not employed or is retired
- ☐ E. Yes, and he/she is also an employee of Southern Glazers. Your spouse's Employee ID No.:

I certify under penalty of perjury, that the foregoing and following is true, correct and current. I understand as an employee of Southern Glazer's Wine and Spirits, LLC that willful falsification of information on this affidavit may lead to disciplinary action.
*This form is not complete without your signature.

EMPLOYEE SIGNATURE	DATE

Spouse's Employer Certification: Complete only if your spouse is employed and you checked Box A in Section 2 above.

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EMPLOYER CERTIFICATION OF SPOUSE MEDICAL BENEFIT COVERAGE
(this section must be completed by your spouse's employer)

1. Is the spouse named above eligible for medical coverage through your company?
   ☐ Yes ☐ No
2. If the spouse is eligible, is he/she enrolled in your medical coverage?
   ☐ Yes, single ☐ Yes, family ☐ No

NAME OF REPRESENTATIVE	COMPANY NAME	PHONE
SIGNATURE OF REPRESENTATIVE	**TITLE**	**DATE**

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RETURN SIGNED FORM VIA MAIL, FAX OR EMAIL AS INDICATED BELOW:

- Mail**: SG Connect People Center,** 14911 Quorum Drive, Suite 150, Dallas, TX 75254
- Email: **peoplecenter@SGWS.com**