BRADLEY
UNIVERSITY

HEALTH PLAN SPOUSAL/DOMESTIC PARTNER SURCHARGE QUESTIONNAIRE

A $125 monthly spousal/domestic partner surcharge will be assessed in addition to the health insurance premium if a spouse/domestic partner is covered by Bradley University health insurance and the spouse/domestic partner is eligible for coverage through an employer but elects not to enroll. If the spouse/domestic partner is eligible for coverage as a Bradley University employee, the surcharge is waived. Please complete and sign this form (in ink), including spouse/domestic partner insurance coverage information if applicable and return to the Human Resource Department.

☐ My spouse/domestic partner is enrolled in the Bradley University sponsored health plan AND has health coverage available through his/her employer but elected NOT to enroll. I understand the $125 monthly surcharge will be assessed in addition to the health insurance premium and authorize a deduction from my payroll check on a pre-tax basis. **(Surcharge applies.)**

☐ I do not have a spouse/domestic partner. **(Surcharge does not apply.)**

☐ My spouse/domestic partner is not employed. **(Surcharge does not apply**.)

☐ I have not elected coverage for my spouse/domestic partner in the Bradley University sponsored health plan. **(Surcharge does not apply**.)

☐ My spouse/domestic partner is a Bradley University employee eligible for health insurance**. (Surcharge does not apply.)**

☐ My spouse/domestic partner is enrolled in the Bradley University sponsored health plan AND does not have health coverage available through his/her employer. **(Surcharge does not apply**.)

☐ My spouse/domestic partner is enrolled in the Bradley University sponsored health plan AND is also enrolled in a health insurance plan through his/her employer. Please complete plan information below. **(Surcharge does not apply.)**

Spouse/Domestic Partner Full Name: _____
(Please print)
Employer Name: _____

Group Medical Plan Name: _____

Group Number _____

Contact for Coverage Verification: Name: _____

Phone Number: _____

If a spouse/domestic partner loses or obtains health coverage through an employer, the Human Resource Department must be notified in writing within 31 days of the date the spouse's/domestic partner's coverage changes. Failure to notify the Human Resource Department within the 31 day grace period will bar an employee from making any changes until the next open enrollment period.

My signature below indicates that the facts set forth on this document are true and complete to the best of my knowledge. I also understand that if my spouse's/domestic partner's group health insurance status changes, it is my responsibility to notify the Human Resource Department in writing within 31 days of such change. **Any false statements or misrepresentation of facts to the University may affect future health plan eligibility as well as creating the right of the University to demand back payment of spousal/domestic partner claims paid by the plan.**

_____ _____
Please Print Name Date

_____
Signature

HUMAN RESOURCE DEPARTMENT
1501 WEST BRADLEY AVENUE – PEORIA, IL 61625 – (309) 677-3223 – FAX (309) 677-3867