

Health Care Spousal Surcharge Form

A \$50 monthly spousal surcharge will be added to your premium if you have elected coverage for your spouse and your spouse is eligible for coverage through his/her employer but elects not to enroll. If your spouse is eligible for coverage as an employee, the spousal coverage surcharge is waived.

 I do not have a spouse or have not elected coverage on my spouse in a company sponsored health plan.

 I have my spouse enrolled in a company sponsored health plan, and my spouse does not have health coverage available through his/her employer; or my spouse does not work; or is self employed.

 I have my spouse enrolled in a company sponsored health plan and my spouse is also enrolled in health coverage through his/her employer.

Spouse name:

Spouse Employer name:

Group # _____

Group Medical Plan name:

Cert. # _____

 I have my spouse enrolled in a company sponsored health plan and my spouse has health coverage available through his/her employer and has elected not to enroll in their health plan. (I understand the \$50 monthly premium surcharge will be applied & authorize a deduction from my pay check on a "pre-tax basis".)

If this form is not received by the Human Resource Department and your spouse is enrolled in coverage, you will be charged the surcharge until this form is received.

If your spouse loses or obtains health coverage through their employer, you have 31 days to notify the Human Resource Department of such change. The Human Resource Department needs to be notified in writing of this and all Family Status changes within 31 days of when the change occurred. Failure to notify the Human Resource Department in a timely manner will bar you from making a change until the next annual open enrollment period.

My signature below indicates that the facts set forth on this form are true and complete to the best of my knowledge. I also understand that if my spouse'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 written on this form or on future forms as it relates to spousal health information shall be considered grounds for disciplinary action.

Name (Please Print)

Signature

Employee #

Date

SAMPLE