BRADLEY University

2018 – 2019 HEALTH PLAN SPOUSAL SURCHARGE DECLARATION

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

☐ My spouse is enrolled in a 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.)**

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

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

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

☐ My spouse is enrolled in a 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 Full Name _____

Employer Name _____

Group Medical Plan Name _____

Group Number

Contact for Coverage Verification: Name:_____

Phone Number:_____

If a spouse 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 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 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 claims paid by the plan.**

Is this a Status Change? **Yes** or **No** If Yes, Date Effective_____

_____

Please Print Name

_____ _____

Signature Signature Date (rev. 11.2018)

HUMAN RESOURCE DEPARTMENT

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