Union Hospital Spousal Eligibility Form for Medical Plan Coverage

If you enroll your spouse on your Union Hospital medical coverage, complete Section 1 and Section 2 below.

(PLEASE PRINT) SECTION 1 – To be completed by the Employee

Employee Name____ Employee #______________

Phone #______________________________

Spouse's Name: ____

Spouse's Employer Name (if applicable) ____

Spouse's Employer Address (if applicable) ____

PLEASE PROVIDE COMPLETE ADDRESSES, AS IT IS NECESSARY FOR VERIFCATION PURPOSES

Qualifying Event (Reason you are submitting this Form):

□ New Hire/Rehire □ Transfer □ Marriage □ Annual Enrollment □ Change in Spouse's Employment or Coverage

Change Date____________________

SECTION 2 – To be completed by the Employee

From the options below, check the box that best describes your spouse's status.

□ My spouse is a Union Hospital employee. I understand that my medical plan election may be either the Employee + 1 or Family.

□ My spouse is unemployed, retired, or disabled. I understand that my medical plan election may be either the Employee + 1 or Family.

□ My spouse is employed or self-employed (full-time or part-time), but is not eligible for medical coverage offered by his/her employer. I understand that my medical plan election may be either the Employee + 1 or Family.

□ I am an ONA member. My spouse is employed and eligible for insurance through their employer, however the cost of Single coverage is greater than 10% of the cost of the UH Single coverage. I have attached documentation indicating the cost of their employers insurance.

If you select any of the boxes above, a spousal surcharge WILL NOT apply to you.

□ My spouse is employed or self-employed and is eligible to enroll in his/her employer's group medical plan. I choose to enroll my spouse on the Union Hospital Plan.

I understand that a spousal surcharge of $200/month, paid on the first and second pays of each month, apply to my spouse's coverage in addition to the normal employee contribution for coverage under Union Hospital Plan.

The spousal surcharge rate for ONA members is based on contract.

I understand that if my spouse has a change in personal/employment status that affects his/her eligibility for coverage, I am required to notify Union's HR Department within 31 days of the change in status date.

Employee Signature____ Date____________________________

My signature above indicates that the information on this form is accurate.