

HOW TO COMPLETE THE SPOUSAL SURCHARGE?

*The Spousal Surcharge only affects employee's who are adding a spouse to their health insurance plan & the spouse is eligible for health coverage at their current employer, but takes KTP's insurance instead as primary coverage.

*Part III : Only complete this section and check off the top box if you are subject to this surcharge. Sign & Date the bottom

If form is NOT returned to Human Resources and you have family coverage the spousal surcharge applies.



SPOUSAL MEDICAL INSURANCE COVERAGE STATEMENT

Meridian Employee: All employees with family coverage complete Part I. Complete Part II and III if your spouse is eligible for other group health coverage. Part III is also to be completed if you are requesting any coverage changes.

Part I. (To be completed by Meridian employee – Please Print)

Name: _____ Employee Social Security #: _____

Spouse Name: _____ Spouse Social Security #: _____

- My spouse is currently employed (complete Part II and Part III below).
- My spouse is unemployed or is a non-working spouse (sign below).
- My spouse is retired (sign below).
- My spouse is self-employed and doesn't offer group coverage to his/her employees and does not have coverage available through an affiliated company (sign below).
- My spouse is a Meridian employee (sign below).
- My spouse currently takes group health insurance through their employer. I will continue to cover my spouse under Meridian's plan as secondary coverage. (sign below and complete Part II).

I hereby certify that the information contained on this form is true and correct. I understand that Meridian reserves the right to verify the information on this form by contacting my spouse's employer and that if my spouse becomes eligible for medical coverage from his/her employer during the plan year, I must notify Meridian's Payroll Department of this change within 31 days. I also understand that intentional misrepresentation of any information constitutes fraud and is a serious violation of company policy, which may result in financial consequences and/or disciplinary action up to and including dismissal.

Employee Signature: _____ Date: _____

Part II. Spouse's Employer Information

Name of Spouse's Company: _____

Company Address: _____

HR Contact Name: _____ Contact Phone Number: (____) - ____ - _____

Does this Company offer Health Insurance? (Yes/No?) _____ Is your spouse eligible for coverage? (Yes/No?) _____

Part III. Spousal Surcharge and Coverage Changes

- I elect to cover my working spouse and I understand the surcharge will apply to my employee contributions effective _____ and beyond unless my situation changes and I notify HR of these changes within 31 days.
- I will remove my spouse only effective _____ as they will be taking coverage under their employer's health plan.
- I will remove my spouse and children effective _____ as they will all be taking coverage under my spouse's employer's health plan.

Employee Signature: _____ Date: _____

Employee Phone Number: _____

*Part II : Complete spouse's employer information, if they are employed.

Please make sure to circle Yes/No if their company offers health insurance & circle Yes/No if your spouse is eligible for health insurance.