FORM B4

SPOUSAL MEDICAL COVERAGE STATEMENT

This form is only needed for Employee + Spouse or Family coverage

If you are electing to include a spouse on your medical insurance coverage, you may be subject to a spousal surcharge, and you must complete and submit this form with your enrollment paperwork.
FAILURE TO RETURN THIS FORM WILL ALSO RESULT IN YOU PAYING THE SURCHARGE.

Section One: Employee Information

Employee Name (Last, First, Initial): ____

Spouse Name (Last, First, Initial): ____

Section Two: Spousal Eligibility for Other Coverage

1. Is your spouse currently employed? ☐ No ☐ Yes
   (including self-employed) *(if no, check the box, skip to the bottom and sign the form)*

2. If you answered yes to question 1, is your spouse eligible for medical insurance through their employer?
   ☐ No ☐ Yes
   (if no, check the box, skip to the bottom and sign the form)

3. If you answered yes to questions 1 and 2, you are subject to pay the spousal surcharge, which will be added on to the medical plan employee contributions deducted from your paycheck.

Section Three: Acknowledgement

- **I answered yes to questions 1 and 2, and I understand the surcharge will apply to my employee contributions since I am electing to cover my working spouse on my medical insurance plan, despite their eligibility for coverage elsewhere.**
- I understand I will be asked to submit a copy of this form each year during annual open enrollment. **Failure to return this form during open enrollment if you have a spouse covered on your plan will result in the spousal surcharge being added to your employee contributions for the following plan year.**
- If your spouse takes group health coverage through their employee, but is covered under Meridian's plan as secondary coverage, speak to your HR representative regarding this surcharge.
- I agree to provide contact information for my spouse's employer, when requested from HR, to verify employment and eligibility. **Name of Spouse's Employer - ___________________________________**

I hereby certify that the information contained on this form is true and correct. I understand that Meridian and Kleen Test Products reserve 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 HR 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:______________________