Spousal Health Care Coverage Eligibility Policy

Spouses of Walsh University employees are eligible for health care coverage under the Walsh University plan at the Employee + Spouse or Employee + Family rate, **if one of the following applies**:

- The spouse is not employed
- The spouse is not eligible for his/her employer's health plan
- The spouse is retired or self-employed and does not have access to a group medical plan

Spouses of Walsh University employees who choose not to enroll in their employer sponsored health plan may enroll under Walsh University's health care plan for an additional cost (spousal surcharge). This cost would be in addition to paying the Employee + Spouse or Employee + Family rate. See the Benefits Guidebook for rates and additional information. It shall be the employee's responsibility to notify the Employer of any change in spousal coverage or any qualifying event in regard to coverage.

If you need to add your spouse to the Walsh health plan, please complete page two.

If you have any questions regarding the completion of this form, please contact the office of Human Resources by e-mailing WalshHR@walsh.edu, or calling 330-490-7137.

****Please return this form by e-mail to WalshHR@walsh.edu, or in person to room 102 in Farrell Hall****

**This form is not used to add or remove a dependent to your benefit plans and is only used to determine if you are to be assessed the spousal surcharge on your bi-weekly medical plan premium.

Spousal Health Care Coverage Eligibility Form

Employee Name: _____Last four of SSN: _____

Spouse's Name: _____Last four of spouse's SSN:_____

Section One

Please check one statement that applies:

1.)_____My spouse does not have access to an employer sponsored health plan because my spouse is:
☐Unemployed/Retired ☐Self-Employed
2.)_____My spouse **is** employed and eligible for a group medical plan.
3.)_____My spouse is employed and is not eligible for his/her employer sponsored health plan. **Please have your spouse's employer complete the section below.**

If one of the first two above options are checked, no other action is required- **please sign and date the form.** If the third option is checked, your **spouse's** employer **MUST** fill out the bottom of this form, and return it. **If for any reason your spouse becomes eligible for health care coverage from another source, you must immediately notify Human Resources.**

As a Plan Participant, I certify that the information on this form is true and accurate. I understand that any misrepresentation or omission of facts may jeopardize my medical benefits coverage and employment status, up to and including termination. I understand the university may verify the information above and that it is my responsibility to update any change to Human Resources. Please sign below and return this form to the HR office.

_____ _____
Employee Signature Date

Section Two

Please have your spouse's employer complete this section if they are employed (if option 3 is checked above).

Company Name: _____

Benefits Representative Contact Name: _____Phone Number: _____

The above indicates your employee is not eligible for medical coverage through your plan. Please provide the reason why:

_____
_____
_____

The above responses are correct to the best of my knowledge.

_____ _____
Benefits Representative Signature Date