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**:

- They are not employed
- They are not eligible for health care coverage from their employer per ACA guidelines
- They are retired or self-employed and do not have access to a group medical plan

Spouses of Walsh University employees **must** enroll in their own employer plan as their primary coverage if one of the following applies:

- they meet the eligibility requirement for health care coverage through their employer as established per ACA guidelines
- they are retired and are eligible for group health care coverage at their previous employer or through their retirement program

Spouses of Walsh University employees who choose not to enroll in their employer's health plan based on cost and/or coverage issues may petition to be enrolled under Walsh University's health care plan. The petition will be evaluated by the Human Resources Department and an additional cost will be assessed. This cost would be in addition to paying the Employee + Spouse or Employee + Family rate. See the Benefits Guidebook for rates and additional information.

- If you are married and your spouse is eligible for Walsh University health care coverage, **only** the top section of the Spousal Health Care Eligibility Form should be completed and returned to HR.

- If your spouse has other medical coverage available and would like to petition to be covered under Walsh's plan, the **entire** Spousal Health Care Eligibility Form must be completed and returned to HR.

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****

Spousal Health Care Coverage Eligibility Form

Employee Name: _____ Last four of SSN: _____

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

Please check the statement that applies:

_____ My spouse **is not** employed and does not have access to a group medical plan.
_____ My spouse **is** employed and does not have access to a group medical plan.
_____ My spouse is retired or self-employed and does not currently have access to a group medical plan.
_____ My spouse is employed/retired and currently has access to a group medical plan and would like to petition, based on cost and/or coverage issues, to be covered under Walsh's health care coverage. **Please have your spouse's employer complete the section below.**

If one of the first three above options is checked, your spouse is eligible to be covered under Walsh University's healthcare plan. If for any reason your spouse becomes eligible for health care coverage from another source, you must immediately notify Human Resources.

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. Please sign below and return this form to the HR office.

_____ _____
Employee Signature Date

Please have your spouse's employer complete this section if they are offered healthcare coverage (if option 4 is checked above)

Employer Name: _____

Benefits Representative Contact Name: _____ Phone Number: _____

Is this employee offered group health care coverage per ACA rules? YES or NO (please circle)

Is this employee eligible or enrolled for your group health care coverage? YES or NO (please circle)

Effective date of enrollment (if applicable): _____

Employer medical insurance/payer/carrier: _____

Premium cost*: _____ [ ] Monthly [ ] Bi-Weekly [} Other: _____

Deductible*: _____ Out-of-pocket max*: _____
Individual Family individual family

*You may also choose to attach a benefit description with the premium, deductible, out-of-pocket max.

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

_____ _____
Representative Signature Date