

## **Spousal Surcharge Waiver**

EMPLOYEE LAST NAME:	EMPLOYEE FIRST NAME:	MI:	LAST 4 DIGITS OF SSN:

## **SPOUSAL SURCHARGE**

CSU employees may choose to have their spouse covered under the CSU Healthcare plan; however, there is a surcharge if your spouse is eligible for medical coverage through his or her employer (whether enrolled in that coverage or not), regardless of your spouse's full-time or part-time status. If you and your spouse work at Central State University, the spousal surcharge does not apply. If your spouse is not eligible for medical coverage through his/her employer, or is retired or not working, see the waiver process below. The spousal surcharge is \$150.00 monthly (\$69.23 per pay period for Bi Weekly employees). The spousal surcharge will be deducted automatically from your paycheck if you have a spouse covered under your medical plan, unless you apply and are

approved for a waiver. This form must be completed each calendar year in order to qualify for the waiver.

## WAIVER PROCESS

To apply for a waiver of the surcharge, please submit this form to Human Resources prior to the end of Open Enrollment or within 30 days from your date of hire or qualified status change. You must submit the waiver form to HR each calendar year to qualify for the spousal surcharge waiver. If your spouse is retired or not working, you are also eligible for the waiver. Waiver forms submitted after the deadline will be effective the pay period following approval from the Benefits Department. The waiver will not be retroactively administered for late forms.

Spouse's Name:					
Spouse's Date of Birth <u>:</u>					
Is your spouse retired?	Yes	No	Is your spouse employed?	Yes	No

Effective Date your spouse retired or became unemployed:

## INFORMATION REGARDING YOUR SPOUSE'S EMPLOYER (To be completed by your spouse's employer):

Spouse's Employer (Company Name):					
Is the spouse listed above eligible for coverage through his/her employer? Yes No					
Name of Spouse's Benefits/HR Administrator:					
Signature:					
Phone Number:					
Date completed by Employer:					
I hereby certify that the information contained on this form is true and correct. I understand that Central State University reserves the right to verify the information provided on this form by contacting my spouse's employer. I also understand that if my spouse becomes eligible for medical coverage from his/her employer during the plan year, I must notify the Benefits Department of this change and will begin having the spousal surcharge deducted from my paycheck.					
Employee Signature:					