

2012-2013 SPOUSAL PREMIUM SURCHARGE FORM



This form is required each enrollment period for active employees and retirees
YOU DO NOT NEED TO COMPLETE THIS FORM IF YOU DO NOT HAVE A SPOUSE OR DO NOT HAVE A SPOUSE ENROLLED IN MEDICAL COVERAGE

A \$50.00 monthly surcharge will be added to your premium if you elected to cover your spouse in a County sponsored medical plan AND your spouse is eligible for coverage through his/her employer, but elects not to enroll. *If your spouse is eligible for coverage as a employee or retiree of the Clayton County Board of Commissioners, the spousal premium surcharge will be waived.*

Please answer each question below by checking yes or no:

1. Medical coverage elected for spouse. Spouse does not work or is self-employed. Yes No
2. Medical coverage elected for spouse. Spouse does not have medical coverage available through his/her employer. (*complete spouse information in section below) Yes No
3. Medical coverage elected for spouse. Spouse is also enrolled in medical coverage through his/her employer. (*complete spouse information in section below) Yes No
4. Medical coverage elected for spouse. Spouse not enrolled in medical coverage that is available through his/her employer. Yes No
5. Spouse is active employee or retiree of Clayton County Board of Commissioners. Yes No
Spouse Name: _____

***COMPLETE THIS SECTION IF YOU ANSWERED YES TO QUESTION #2 OR #3 ONLY:**

Spouse Name: _____

Spouse Employer Name: _____

Employer Telephone #: _____

I understand that if I elect coverage for my spouse and I fail to submit this form during each enrollment period, I will be charged the premium surcharge until the form is received in the HR/Benefits Division. Any premiums deducted due to the failure of submitting this form will not be refunded.

I understand the \$50.00 monthly premium surcharge will be applied to my medical deductions if applicable, and authorize the additional premium to be deducted on a "pre-tax" basis. Premium surcharges deducted from pension checks will be deducted on an "after-tax" basis.

By signature below I confirm that all information provided on this form is true and correct to the best of my knowledge. Any false statements on this form or on future forms as it relates to spousal health information shall be considered as grounds for disciplinary action up to and including termination of employment.

Print Name

Employee Signature

Date

Employee # _____

Employment Status: Active Retiree