L'OREAL TRAVEL RETAIL AMERICIAS HEALTH BENEFIT PLAN
Supplemental Application for Spouse Medical Coverage

Preferred BENEFIT ADMINISTRATORS INCORPORATED

If you would like to enroll your spouse in the medical plan offered by L'Oreal Travel Retail Americas, Inc. the following information must be completed in order to determine if your spouse is eligible under the plan.

Employee Name: **Employee Member ID Number:**

Spouse Name:

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1. Is your spouse employed? ☐ **No** ☐ **Yes**

If you answered **No,** your spouse is eligible for coverage and no further information is needed. Please sign below and return this form to Human Resources with your enrollment application.

If you answered **Yes,** please proceed to question #2.

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2. Does your spouse have access to health benefits through his/her employer? ☐ **No** ☐ **Yes**

If you answered **No,** your spouse is eligible for coverage and no further information is needed. Please sign below and return this form to Human Resources with your enrollment application.

If you answered **Yes,** please complete the information below.

Is your spouse currently covered by his/her employers' medical plan? ☐ **No** ☐ **Yes**

If you answered **No** indicating that your spouse is not currently covered through his/her employer's medical plan, your spouse is *not* eligible for medical benefits through the L'Oreal Travel Retail Americas Health Benefit Plan.

If you answered **Yes** indicating your spouse is currently covered through his/her employer's medical plan please provide the following information:

Name of Insurance Company: _____

Group #: _____ Member ID#: _____

Insurance Company Telephone Number: _____

If your Spouse ***has access*** to health benefits through his/her employer and is ***not enrolled*** for coverage, your spouse is ***not eligible*** for coverage through the L'Oreal Travel Retail Americas Health Benefit Plan.

If your Spouse ***has access*** to health benefits through his/her employer and ***is enrolled*** for coverage, your spouse ***is eligible*** for coverage through the L'Oreal Travel Retail Americas Health Benefit Plan for *secondary coverage*. Please sign below and return this form to Human Resources with your enrollment application.

By signing this form I understand that my spouse is *only* eligible for medical benefits through the L'Oreal Travel Retail Americas Health Benefit Plan if he/she is not employed or does not have access to employer sponsored medical coverage if employed. If he/she is currently covered through an employer sponsored medical plan, he/she is only eligible for secondary coverage through the L'Oreal Travel Retail Americas Health Benefit Plan.

I further understand that it is my responsibility to immediately notify Human Resources if any change should occur that would cause my spouse to lose eligibility. If I fail to notify Human Resources within 30 days of this change, I will be responsible for all claims incurred from the date eligibility is lost. In addition, late notification of loss of eligibility will void my spouses' right to elect COBRA continuation coverage. The information provided on this application for coverage is true and accurate to the best of my knowledge.

_____ _____

Employee Signature **Date**