



REGIONAL MEDICAL CENTER

For Life!

Employee's Name: _____

Spousal Surcharge Disclosure/Waiver Form

If you enroll your Spouse in one of the medical plans, you must complete this Waiver to indicate if your Spouse has other coverage. Meadows Regional Medical Center will automatically apply a spousal surcharge*, in the amount of \$25 per pay period, if you do not complete and return the Waiver. -

*This surcharge is in addition to the normal monthly cost for the medical option you select. Please note that this fee is subject to change on an annual basis.

This form must be completed and returned to Meadows Regional Human Resources within 30 days of eligibility.

This surcharge can be waived under the following conditions (check one):

- ☐ Spouse enrolled under his/her own employer's medical insurance;
- ☐ Spouse's employer has no health insurance to offer; or
- ☐ Spouse is employed by Meadows Regional.

In order to waive the surcharge under items one and two list above, you must have the following information completed by your spouse's employer:

Spouse's Employer Name _____

Employer's Address _____

City/State/Zip _____

Phone Number _____ () _____

Insurance Company Name _____

Insurance Company Address _____

Policy or Group No _____

Spouse's Identification Number _____

Insurance Company's Phone Number _____

Any status change to your spouse's coverage with **their** employer must be **reported to your Meadows Regional Medical Center Human Resources Department within 30 days**. Any employee found providing a fraudulent form will receive disciplinary action up to and including termination of employment.

To Be Completed By The Benefit Coordinator:

| | | | |
|------------------------------|--|--------------------|--|
| Medical Plan: | | Department: | |
| | | | |
| Authorized Signature: | | Date: | |
| | | | |