MEDICAL PLAN SPOUSAL SURCHARGE FORM

A $1,200 annual spousal surcharge ($100 monthly / $46.15 bi-weekly) will be added to your medical plan premium if you elect coverage for your spouse and your spouse is eligible for coverage through his/her employer but elects not to enroll in that plan. If your spouse is a Franklin & Marshall employee, the spousal surcharge is waived.

☐ My spouse is an employee of F&M College.

☐ My spouse is enrolled on the F&M College medical plan and my spouse has health coverage available through his/her employer and has elected not to enroll in their medical plan. I understand the $1,200 annual surcharge ($100 monthly / $46.15 bi-weekly) will be applied and authorize a deduction from my paycheck on a pre-tax basis.

☐ My spouse is enrolled on the F&M College medical plan and does not have medical coverage available through his/her employer; or my spouse does not work; or my spouse is self-employed; or my spouse is Medicare eligible and doesn't have access to his/her employer's group medical plan.

☐ My spouse is enrolled on the F&M College medical plan and my spouse is also enrolled in medical coverage through his/her employer.

Spouse Name: _____

Spouse Employer Name: _____

Spouse Employer Medical Plan Name : _____

Spouse Employer Medical Group #: _____

If this form is not received by the Office of Human Resources and your spouse is enrolled on an F&M medical plan, you will be charged the surcharge until this form is received – no reimbursements will be made.

If your spouse loses or obtains medical coverage through their employer, you have 31 days to notify the Office of Human Resources of such a change. The Office of Human Resources needs to be notified in writing of this and all Family Status changes within 31 days of when the change occurred. Failure to notify the Office of Human Resources within 31 days will bar you from making a change until the next annual open enrollment period.

Family Status Change: _____ Date of Change: _____
(i.e., Gain/Loss of Coverage, Marriage, Divorce, etc.)

My signature below indicates that the facts set forth on this form are true and complete to the best of my knowledge. I also understand that if my spouses' group medical insurance status changes, it is my responsibility to notify the Office of Human Resources in writing within 31 days of such change. False statements on this document would be considered employee misconduct and subject to discipline and any claims paid for your spouse will be reversed.

_____ _____
Employee Name (Please Print) Employee ID Number

_____ _____
Employee Signature Date