Pennsylvania's STATE SYSTEM of Higher Education

Spouse/Domestic Partner Health Care Enrollment Attestation
For Employees Hired Prior To July 1, 2013

This form must be fully completed. Failure to do so will impact your spouse's/domestic partner's health care coverage. For employees hired prior to July 1, 2013, If you wish to enroll your spouse/domestic partner in the State System plan and that person is eligible for single coverage in their own employers health plan and that single coverage is available at no cost to the employee, then your spouse/domestic partner must enroll in that coverage as a condition for enrollment for secondary coverage in the State System plan.

Employee Name: _____ Spouse/Domestic Partner Name: _____

Employee Hire Date: _____

Section I: Spouse/Domestic Partner Employment

My spouse/domestic partner is:

Employed ☐ (Go to section II) Unemployed, Retired or Self-Employed ☐ (Go to section IV)

Note: your spouse/domestic partner is not self-employed if he/she receives a W-2

Section II: Additional Employment Information (Complete this section **only** if your spouse/domestic partner is employed.)

Spouse's/Domestic Partner's Employer: _____

Employer Address: _____

Employer Phone Number: _____

Does your spouse's/domestic partner's employer offer health care coverage for which he/she is eligible?

Yes ☐ (Continue to next question) No ☐ (Go to section IV)

Is single coverage available to your spouse/domestic partner at no employee cost (i.e. fully employer paid)?

Yes ☐ (Continue to next question) No ☐ (Go to Section IV)

Is your spouse/domestic partner enrolled in that plan?

Yes ☐ (Go to section III) No ☐ (continue to next question, Employer Information Form required)

If your spouse/domestic partner is not currently enrolled in their own employer health plan, they must enroll as soon as possible. Provide the date upon which their enrollment will be effective: _____

Section III: Spouse/Domestic Partner Health Care Coverage

Insurance Provider: _____

ID/Policy Number: _____

Section IV: Must be read and signed by employee

I declare that all information above is true and correct to the best of my knowledge. If my spouse's/domestic partner's employer offers fully-paid employee only health coverage at no cost to the employee, my spouse/domestic partner must enroll in his/her employer's plan. I understand that if my spouse/domestic partner does not enroll, he/she is ineligible to be covered as a dependent in the PASSHE health plan. I further understand that if enrolled, my spouse's/domestic partner's group health plan from his/her employer is his/her primary insurance plan. I understand that eligibility for coverage and payment of benefits under the PASSHE health plan in all instances is subject to the terms of the plan and that any false or misleading information I provide regarding the status of any dependent and any other medical or supplemental coverage that may be applicable may result in the suspension or termination of coverage under the health plan and may require repayment to the plan of any benefits paid under the plan. I understand that I must inform my employer of any changes in the employment status of any dependents which may affect their eligibility under the plan and that my failure to do so may result in the loss of coverage and repayment of any amounts paid on their behalf. If my spouse's/domestic partner's employment and/or eligibility for health care coverage changes, I will notify my University's Human Resources Office immediately. I also understand that I may be required to provide further documentation in the event of a dependent eligibility audit.

Employee Signature (Required): _____ **Date:** _____

FOR HR OFFICE USE ONLY

Type of Attestation: _____ Year of Attestation: _____

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