Working Spouse Premium Election Form

The Working Spouse Premium applies if you elect to cover a spouse/domestic partner

Benelect medical insurance plan who has access to group health insurance coverage through [illegible] to those spouses/domestic partners who could obtain coverage from another employer.

_____ _____

Employee Name (please print) *Employee ID*

☐ **Yes**, my spouse/domestic partner has access to group health insurance coverage from another employer. I understand that a $150 per month premium will be charged for covering him/her on my Benelect medical insurance plan.

☐ **No**, my spouse/domestic partner does not have access to group health insurance coverage because he/she ([illegible]):

- ☐ is unemployed
- ☐ is self-employed
- ☐ is employed, but does not qualify for or is not offered group health insurance coverage
- ☐ [illegible]
- ☐ is retired

This Election is effective as of _____/_____/_____

I certify that to the best of my knowledge my election is an accurate reflection of my personal facts and circumstances. I understand [illegible] Benefits Administration within 30 days of such change.

_____ _____

Signature *Date*

Return completed form to

Benefits Administration, 224 Crawford Hall, LC 7043

FOR BENEFITS ADMINISTRATION USE ONLY

Benefits Representative Signature _____ Date _____