This Form <u>must</u> be completed, signed and returned with Open Enrollment Form

DOVER AREA SCHOOL DISTRICT — PROFESSIONAL/ADMIN SPOUSAL ELIGIBILITY CERT.

Medical Healthcare Plan only — July 1, 2023 – June 30, 2024

NAME (printed):________________________________

All employees who are enrolling into DASD Medical Healthcare Plan must complete and return this form along with their Open Enrollment Form by:

<u>April 21, 2023</u>

1. Do you have a spouse?

   YES ________ *If Yes, print your spouse's name below and continue to question #2*

   SPOUSE NAME (printed):____

   NO________ *If No, then continue to question #8*

2. Are you planning on covering your spouse on Dover Area School District Medical Healthcare Insurance?

   YES ________ *If Yes, continue to question #3*

   NO ________ *If No, then continue to question #8*

3. Is your spouse employed? (Choose only 1)

   YES________ *If Yes, continue to question #4*

   NO________ *If No, then continue to question #5*

   YES at DASD__________ *If Yes, continue to question #8*

   YES, Self-employed ________ *If Yes, continue to question #8*

4. Is your spouse eligible for medical insurance at his/her place of employment?

   YES________*If Yes, continue to question #6*

   NO__________ *If No, then continue to question #7*

5. Initials: ________ I understand that by answering **<u>'NO'</u>** to question #3 above that my spouse is <u>not employed</u>. I also understand it is my responsibility to update the Human Resources department should his/her employment status change. Such notification and additional paperwork must be submitted within 30 days from the date of the change. ***Please continue to #8.***

6. Initials: ________ I understand that by answering **<u>'YES'</u>** to question #4 above I am stating that my spouse <u>is eligible to enroll in his/her employer's medical healthcare plan</u>. I also understand that I must pay an additional surcharge of **<u>$150.00 per month per the contract</u>** in addition to the normal applicable premium share to enroll my spouse in the Dover Area School District medical healthcare plan. ***Please continue to #8.***

7. Initials: ________I understand that by answering **<u>'NO'</u>** to question #4 above that my spouse <u>is not eligible to enroll in his/her employer's medical healthcare plan</u>. I also understand that, if my spouse is employed but is not eligible to enroll in his/her employer's medical healthcare plan, I must have the necessary documentation completed by my Spouse's employer **<u>("Verification of Eligibility for Health Coverage Form")</u>** if I plan to enroll my spouse in the Dover Area School District medical healthcare plan in order to avoid paying the surcharge of $150.00 per month in addition to the normal applicable premium share. I understand that the Verification form must be received by the DASD Human Resources by **May 5, 2023.** ***Please continue to #8.***

8. Employee Certification

Signature of Employee:________________________ **Date**:______________________

By my signature on this form, I certify to the Dover Area School District that all information and documentation is true, correct and current as of the date I signed. I understand that it is my responsibility to update any changes to my Marital Status or my Spousal Eligibility Status and Certification with the **<u>Human Resources Department</u>** should his/her eligibility change. Such notification must be submitted within 30 days from the date of the change. I further understand that if I knowingly submit false information, I may be subject to disciplinary action, up to and including termination. Furthermore, the undersigned authorizes the Dover Area School District to verify all documents provided and may contact the appropriate institution or organization to verify the facts stated herein.