

This Form must be completed, signed and returned with Open Enrollment Form

DOVER AREA SCHOOL DISTRICT
Medical Healthcare Plan only

SUPPORT SPOUSAL ELIGIBILITY CERTIFICATION
July 1, 2023 – June 30, 2024

NAME (printed): _____

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 1)

YES _____ *If Yes, continue to question #4*

YES at DASD _____ *If Yes, continue to question #8*

NO _____ *If No, then continue to question #5*

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 '**NO**' to question #3 above that my spouse is not employed. 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 '**YES**' to question #4 above I am stating that my spouse is eligible to enroll in his/her employer's medical healthcare plan. I also understand that I must pay an additional surcharge of **\$185.00 per month per the contract** 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 '**NO**' to question #4 above that my spouse is not eligible to enroll in his/her employer's medical healthcare plan. 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 ("**Verification of Eligibility for Health Coverage Form**") if I plan to enroll my spouse in the Dover Area School District medical healthcare plan in order to avoid paying the surcharge of \$185.00 per month in addition to the normal applicable premium share. I understand that the Verification form must be received by the DASD Human Resources **May 5, 2023**. **Please continue to #8.**

All employees who are enrolling into DASD Medical Healthcare Plan must complete and return this form along with their Open Enrollment Form by:
April 21, 2023

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 **Human Resources Department** 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.