

SPOUSE EMPLOYMENT DATA FORM

➔ YOU AND YOUR SPOUSE MUST SIGN WHERE INDICATED BELOW.

1. EMPLOYEE INFORMATION.

1. Full name _____
2. SSN _____
3. Address _____
4. Marital status: single married/date _____ divorced other (explain)

2. SPOUSE INFORMATION.

1. Full name of spouse _____
2. Spouse's SSN _____
3. Spouse's employment status: not employed employed full-time employed part-time self-employed
 retired
4. Name and address of spouse's employer

5. Contact person and telephone number at spouse's employer

6. Date of hire _____
7. Does spouse's employer offer a healthcare plan for its employees? yes no
8. Is spouse eligible to enroll in employer's healthcare plan? yes no
9. Is spouse enrolled? yes no

WORKING SPOUSE RULE: This Plan requires that your spouse enroll in his or her employer's health plan. If your spouse fails to enroll, this Plan will remove your spouse's coverage effective 2/28/21. If you fail to complete this form, his or her coverage will be terminated. If your spouse's employer offers health coverage, but your spouse is not eligible to participate, you must submit a letter from the employer on company letterhead that explains the reason for his or her ineligibility.

There is a hardship exemption to the working spouse rule for spouses earning: a) less than \$20,000 per year; or b) between \$20,000 and \$35,000 per year if the coverage costs your spouse more than \$265 per month. Answer Numbers 10a and 10b below, **ONLY** if you want to claim the hardship exemption. In addition, attach a letter attesting to wages and cost of coverage from the employer, on company letterhead.

10a. Annual salary (for current calendar year) \$ _____ 10b. Amount employee pays per month \$ _____

11. If not enrolled, when is spouse's next enrollment opportunity? _____ When would coverage begin? _____

Answer the following questions if spouse is enrolled in his or her employer's healthcare plan.

12. Give name and address of insurance company/plan (or attach a photocopy of both sides of medical ID card)

13. Plan information: Group No. _____ Individual ID# _____

- Check all that apply:
- Major medical/PPO
 - High deductible HRA
 - HMO
 - Other
 - single coverage
 - family coverage
 - other (explain) _____
 - dental
 - vision

3. SIGNATURES.

EMPLOYEE'S SIGNATURE

I affirm that the information given on this form is true and correct to the best of my ability.

➔ Employee's Signature _____ Date _____

SPOUSE'S SIGNATURE (AUTHORIZATION TO RELEASE INFORMATION)

I hereby authorize my employer to release information regarding my employer's health plan, and my eligibility for coverage under that plan, to Parent Child Development Center. This authorization shall remain in effect as long as I am eligible for benefits under the PCDC Group Health Insurance Plan. I affirm that the information provided on this form is true and correct to the best of my ability.

➔ Spouse's Signature _____ Date _____

4. SUBMIT TO: Parent Child Development Center Human Resources Department.

Mail completed form to:

PCDC
Human Resources Department
702 Main Street
West Point, VA 23181