SMITHAMUNDSEN LLC

SPOUSE/DOMESTIC PARTNER GROUP COVERAGE CERTIFICATION

You must complete this form if you elect coverage for your spouse or domestic partner under the medical plans. Please read the following statements, mark the appropriate boxes, sign and return this form to Raquel Candelaria in Human Resources.

COMPLETE THIS SECTION ONLY IF YOUR SPOUSE OR DOMESTIC PARTNER DOES NOT HAVE ACCESS TO OTHER GROUP COVERAGE

Medical – I certify that my spouse/domestic partner is not currently eligible for coverage under another group medical plan for the following reason (check only one):

- ☐ My spouse/domestic partner is not employed.
- ☐ My spouse or domestic partner's employer does not offer benefits or my spouse/domestic partner is self-employed.
- ☐ My spouse/domestic partner's employer has a waiting period for benefits. My spouse/domestic partner will be eligible for benefits on _____ (date).

I understand that primary coverage for health care expenses will be available through SmithAmundsen for my spouse or domestic partner. I further understand and agree that if my spouse/domestic partner gains access to group insurance coverage through his/her employer, I will notify Human Resources and my spouse/domestic partner will be removed from the plan.

COMPLETE THIS SECTION ONLY IF YOUR SPOUSE OR DOMESTIC PARTNER HAS ACCESS TO OTHER GROUP COVERAGE AND YOU WISH TO ENROLL HIM/HER UNDER THE SMITHAMUNDSEN HEALTH PLAN

- ☐ My spouse or domestic partner has access to a group health plan through his/her employer, however the plan is not a comprehensive medical plan (i.e. one that includes both inpatient and outpatient medical care). ***If you have checked this box, you must submit a verifiable copy of the other health plan benefits available.***

- ☐ My spouse or domestic partner has access to a group health plan through his/her employer. Although he/she has a coverage option under another group plan, I am electing to cover him/her under the SmithAmundsen health plan. ***If you have checked this box, you will be assessed the applicable surcharge for spouses/domestic partners that have access to other group coverage.***

Authorization

I certify that these statements are true and acknowledge that falsifying this document or failing to update this information within 30 days of a change is grounds for disciplinary action up to and including termination of employment.

Name _____ SS# _____

Signature _____ Date _____ Location _____