STATE COLLEGE AREA SCHOOL DISTRICT
EMPLOYER INFORMATION FORM FOR SPOUSE/DOMESTIC PARTNER

Employees' spouses or domestic partners who are employed and who are eligible for comparable health care insurance through their employer will be eligible for the District's health insurance plan only if the employee pays the full premium cost differential of the selected coverage.

If your spouse/domestic partner is not eligible for health insurance coverage as described above, and you desire to include your spouse/domestic partner in the District's insurance plan, then complete this form and return it to the Human Resources Office.

Is your spouse/domestic partner employed? ____ Yes ___ No

If yes, please complete information below:

Spouse/Partner Full Name: ____

Employment Status: ____ Full-time ____ Part-time Benefit Eligible: ____ Yes ____ No
(If your spouse/partner is benefit eligible, then attach a copy of the applicable Summary Benefits Plan and employee premium.)

Employer of Spouse/Partner:

Company Name: ____

Company Address: ____

____

Company Phone Number: ____

My signature below indicates that the facts set forth on this form are true and complete to the best of my knowledge. I understand that if my group health insurance status changes, including my spouse/domestic partner's eligibility for health care insurance through employment, it is my responsibility to notify the Human Resources Office in writing within 30 days of such change. If I fail to notify the Human Resources Office in a timely manner, I will not be able to make any changes until the next annual open enrollment period.

Any false statements written on a form or failure to provide updated information shall be considered grounds for disciplinary action, including dismissal.

Name (Please Print):____

Signature: ____

Date: ___________________________ Employee #: ________________________________

HR Office:

Spouse/partner coverage approved for 2019. Signed ____