WORKING SPOUSE/DOMESTIC PARTNER PREMIUM
EMPLOYEE STATEMENT AND REQUEST FOR WAIVER

Section I: TO BE COMPLETED BY CARILION CLINIC EMPLOYEE (please print)	
Employee Name	Carilion Badge #
Employee Email Address	Employee Phone #
Spouse/Domestic Partner Name	Spouse DOB

Choose the response that applies to you and your spouse/domestic partner enrolled in the Carilion Clinic Medical Plan:

☐ My spouse/domestic partner is employed and is eligible for employer-sponsored group health coverage through his/her employer. I am choosing to keep my spouse/domestic partner on the Carilion Clinic Medical Plan and understand the additional Working Spouse Premium of $50 per pay period will apply.	**If you checked this box, you must sign below. Then return this page ONLY to Human Resources.** *(Page 2 is not required for this selection.)*
☐ My spouse/domestic partner is not employed, is self-employed or is retired. ☐ My spouse/domestic partner also works for Carilion Clinic and is eligible for coverage as an employee, but I cover both of us on my plan. Spouse/Domestic Partner's Carilion Badge Number/Employee ID _____	**If you checked either of these boxes, you and your spouse/domestic partner must sign below. Then return this page ONLY to Human Resources.** *(Page 2 is not required for this selection.)*
☐ My spouse/domestic partner is employed but is not eligible for employer-sponsored group health coverage through his/her employer or his/her employer does not offer employer-sponsored group health coverage.	**If you checked this box, you and your spouse/domestic partner must sign below. Section II must be completed by your spouse's/domestic partner's employer. Return both pages to Human Resources.**

I acknowledge the information on this form is accurate to the best of my knowledge. I agree to inform Carilion Clinic Human Resources immediately regarding the employment of my spouse/domestic partner or eligibility for employer-sponsored group health coverage. I understand that I may be asked to provide documentation verifying the employment status of my spouse or domestic partner at any time and that I may be subject to disciplinary action, up to and including termination of employment, if I have falsified information.

Employee Signature **Date**

Spouse/Domestic Partner Signature **Date**

CARILION CLINIC HUMAN RESOURCES USE ONLY	
WSP waived? ☐ YES ☐ NO	Effective Date
HR Initial	Date

Return this form to Human Resources. Interoffice mail: CASB Suite 1400
Fax: 540-857-5209 Email: HRServiceCenter@carilionclinic.org

CARILION CLINIC

CARILION CLINIC EMPLOYEE MEDICAL PLAN
REQUEST FOR WAIVER – EMPLOYER STATEMENT

Carilion Clinic Employee Name	Carilion Clinic Badge #
Employee Email Address	Employee Phone #
Spouse/Domestic Partner Name	Spouse DOB

Section 2: TO BE COMPLETED BY SPOUSE'S/DOMESTIC PARTNER'S EMPLOYER

Instructions to employer: Please certify the spouse or domestic partner named above is employed by your company and indicate his or her eligibility for medical benefits.

I certify that the spouse or domestic partner named above is employed by our company and is not eligible for medical benefits because:

☐ This employer does not provide medical coverage to employees.

OR

☐ The employee named as spouse or domestic partner above is not eligible for medical coverage through this employer due to employment status or hours worked.

Name of Benefits/HR Administrator (please print)	Contact phone number for Benefits/HR Administrator
Title of Benefits/HR Administrator	Contact email address for Benefits/HR Administrator
Benefits/HR Administrator Signature	Date Signed

Return this form with the Employee Statement (Page 1) to Human Resources.