CARILION CLINIC EMPLOYEE MEDICAL PLAN

REQUEST FOR WORKING SPOUSE/DOMESTIC PARTNER PREMIUM WAIVER

EMPLOYER STATEMENT OF COVERAGE

Section 1: TO BE COMPLETED BY CARILION CLINIC EMPLOYEE (please print)	
Employee Name	**Carilion Badge #**
Employee Email Address	**Employee Phone #**
Spouse/Domestic Partner Name	**Spouse DOB**
Is your spouse/domestic partner employed by Carilion Clinic? ☐ YES ☐ NO	**If yes, Spouse/Domestic Partner's Carilion Clinic Badge #**

By signing below, I acknowledge the information on this form is accurate to the best of my knowledge. I agree to inform Carilion Clinic Human Resources immediately if my spouse/domestic partner becomes eligible for medical coverage through his/her employer. I also understand that falsification of information and documents is subject to disciplinary action, up to and including termination of employment.

Employee Signature **Date**

Spouse/Domestic Partner Signature **Date**

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**

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

Return this form to Human Resources, 1212 Third St. SW, Roanoke, VA 24016
Fax: 540-857-5209 Email: HRServiceCenter@carilionclinic.org

CARILION CLINIC