Request for Waiver of Spousal Surcharge

You elected to cover your spouse under Muhlenberg College's medical plan. As a result, a **$125 monthly/$57.69 bi-weekly spousal surcharge** will be added to your medical insurance premium each pay period. A waiver of surcharge is available only if:

- Your spouse is a Muhlenberg College employee;
- Your spouse does not have access to employer - sponsored medical coverage;
- Your spouse is self-employed and does not offer health insurance to their employees; or
- Your spouse is not employed.

A Spousal Surcharge applies whenever an employee elects spousal medical coverage. A request for waiver of this surcharge is not automatic - you must request it each year and deadlines apply:

- To request a waiver of the surcharge as part of the Open Enrollment process, complete this form and email it to Human Resources, at hr@muhlenberg.edu no later than January 3, 2023.
- To request a waiver of the surcharge as a result of a Qualifying Life Event outside of Open Enrollment (marriage, birth, adoption, death of a dependent, divorce, change in benefit-eligibility of you or your spouse), in addition to notifying HR of any requested benefit changes within 30 days of the qualifying event date, you must also email this form to HR, at hr@muhlenberg.edu within that same 30-day window.

Note: Refunds are not issued for forms submitted after the above deadlines - so don't delay.

Section 1: Muhlenberg Employee Information

Employee Name (please print):	
Spouse Full Name (please print):	

Section 2: Select one of the choices below

My spouse:

☐ is a Muhlenberg employee – return to HR.

☐ is self-employed – skip to Section 4.

☐ is not employed – skip to Section 4.

☐ is employed but does not have an employer health plan-complete Section 3.

Section 3: Employer Verification – To be Completed by Spouse's Employer

Employer - Please check the appropriate box that best describes the above named Spouse:

☐ Employee is not eligible for employer-sponsored medical coverage.

☐We do not offer employer-sponsored medical coverage.

Company Name (please print):	
Company Representative Name (please print):	
Company Representative Title (please print):	
Company Representative Signature &Date:	
Company Representative email & phone number:	

Section 4: Acknowledgement

I reviewed this form in its entirety, understand its content, and acknowledge that the information provided is accurate. I further understand that falsifying information regarding my spouse's medical coverage will result in denial of this request.

Employee Signature:	
Date:	