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|  | | | **Request for Waiver of Spouse/Partner Surcharge** | | | | | |
| You have elected to cover your spouse/partner under a University medical plan. As a result, a $100 monthly spouse/partner surcharge will be added to your medical insurance premium each month. Your waiver to be excluded from this surcharge is not automatic — you must request it each year. A waiver is available only if one of the following is true:   * Your spouse/partner is not employed. * Your spouse/partner does not have access to employer-sponsored medical coverage with his/her employer where the employer pays at least 50% of the premium cost. * Your spouse/partner is enrolled in medical coverage at his/her current or former employer. Lehigh's insurance will be secondary for him/her.   Details about the spouse/partner surcharge can be found in the [Flexible Benefits Enrollment and Reference Guide](http://hr.lehigh.edu/benefits), under Benefits on the Human Resources home page.  Whether you have elected medical coverage for your spouse/partner during the Open Enrollment period or as the result of a [Qualifying Life Event](http://www.lehigh.edu/%7Einhro/benefits_life_events.html) (QLE), you will automatically be assessed the Spouse/Partner Surcharge of $100/month. To determine if you qualify to have this charge waived, you must complete this request. ***Spouse/partner surcharge amounts you pay before successfully completing the request cannot be refunded to you, even if the completed result confirms that you should not pay the surcharge going forward.***  To qualify for a waiver of the spouse/partner surcharge as a result of a Qualifying Life Event, your responses to this request **MUST** be received in Human Resources by either the 5th or the 20th of the month to avoid the waiver being applied to the next pay following the coverage change date. | | | | | | | | |
| **Section I: Lehigh Employee Info** | | | | | | | | |
| Employee Name: | |  | | | | |  | |
| Lehigh Email: | |  | | @lehigh.edu | | |  | |
| Spouse/Partner's Full Name: | |  | | | | |  | |
|  | | | | | | | | |
| **Select one of the choices below:** | | | | | | | | |
| ***My spouse/partner is employed and*** | | | | | | | | |
| does not have access to employer-sponsored medical coverage for which the employer pays at least 50% of the cost. | | | | | | | | |
| has access to employer-sponsored medical coverage for which the employer pays at least 50% of the cost, but chooses not to participate in the medical coverage offered. | | | | | | | | |
| is enrolled in medical coverage through his/her employer. | | | | | | | | |
| ***My spouse/partner is not employed and*** | | | | | | | | |
| does not have access to medical coverage through a former employer. | | | | | | | | |
| has access to medical coverage for which a former employer **does not pay at least 50% of the cost**. | | | | | | | | |
| has access to medical coverage for which a former employer **pays at least 50% of the cost**, but chooses not to participate in the medical coverage offered. | | | | | | | | |
| is enrolled in medical coverage through a former employer. | | | | | | | | |
| ***My spouse/partner is self-employed (or an independent contractor) and*** | | | | | | | | |
| does not provide medical coverage to his or her employees | | | | | | | | |
| provides employer-sponsored medical coverage to his or her employees | | | | | | | | |
| **Section II: Spouse/Partner Employer Info** | | | | | | | | |
| **I authorize Lehigh University to contact my spouse/partner’s employer for verification.** | | | | | | | | |
| Employer Name: | |  | | | | |  | |
| Employer Telephone Number: | |  | | | | |  | |
|  | | | | | | | | |
| **Section III: acknowledgment** | | | | | | | | |
| I acknowledge that the information provided is true and complete to the best of my knowledge. Should I experience a Qualifying Life Event and want to make a change to my benefit elections, I understand that I am responsible for notifying Human Resources within 30 days of the event's occurrence. If I do not notify Human Resources within 30 days of the qualifying event, I must wait for the next Open Enrollment period (or another qualifying life event) to make a change to my benefits. I further understand that falsifying information regarding my spouse/partner’s medical coverage will result in, at a minimum, the request for waiver of the spouse/partner surcharge being denied. | | | | | | | | |
| Employee Signature: |  | | | | Date: |  | |  |
|  | | | | | | | | |