

MUHLENBERG
COLLEGE

2009 Spouse or Domestic Partner Medical Coverage

This form must be completed by all faculty and staff who elect to cover a spouse or domestic partner on a Muhlenberg College sponsored medical plan in 2009.

Your Name: _____

Your Spouse or Partner's Name: _____

Section I: Spouse or Partner's access to coverage

Please indicate "Yes" or "No" as appropriate.

a. Is your spouse or partner employed?

Yes No (**Go to Section II**)

If "yes", Name of Employer: _____

b. Does your spouse or partner have access to employer sponsored medical insurance for which his/her employer pays at least 70% of the individual premium cost?
(If you are unsure if the employer pays at least 70% of the premium cost, the benefits office at your spouse or partner's employer should be able to provide that information.)

Yes No (**Go to Section II**)

c. Will your spouse or partner enroll in the employer sponsored medical insurance available through his/her employer?

Yes (**Go to Section II**) No

d. Are you electing coverage for your spouse or partner on one of Muhlenberg's medical insurance plans at a cost of \$50 per month in addition to the regular employee deduction for the coverage?

Yes No

Section II. Confirmation and Authorization

My signature below indicates that the above information is accurate.

Signature _____ Date _____

If I have answered "Yes" to Question d., Section I above, I authorize Muhlenberg College to reduce my pay by the regular employee deduction plus \$50 per month on a "before-tax" basis as I am electing coverage for my spouse or partner who has access to employer sponsored coverage with his/her employer.

PLEASE RETURN ALL FORMS TO HUMAN RESOURCES