UNIVERSITY *of*
DUBUQUE

Spousal Coverage Statement
Complete and return to H.R. ASAP

The University of Dubuque Health Plan contains a Spousal Coverage Provision effective April 24, 2009 for all new hires and January 1st, 2010 for all participants on the plan before April 24, 2009. The provision requires a working spouse with other coverage available through their employer to take that coverage, if eligible, in order to qualify for secondary coverage under this plan.

Complete SECTIONS I & II, and Section III, if applicable.

SECTION I
(To be completed by the employee)

Employee's Name:____

Employee's Social Security Number:______________________________

SECTION II
(To be completed by spouse: check one box only)

Spouse's Name(s): ____

Spouse's Social Security Number(s): ______________________________

- ☐ I certify that I am not employed at this time. (Sign and return form to H.R.)
- ☐ I am currently employed and SECTION III is completed below.
- ☐ I am declining coverage in the University of Dubuque Health Plan. I understand I will be subject to late enrollment provisions of the Plan if I request coverage at a later date. (Sign and return form to H.R.)

Signed: ______________________________ **Date:**______________

SECTION III
(To be completed by spouse's employer, if applicable)

Name of Company: ____

The above named spouse: (check all that apply)

- ☐ is eligible for the Company sponsored medical plan;
- ☐ is eligible for the Company sponsored dental plan;
- ☐ is covered under the Company sponsored medical plan;
- ☐ is covered under the Company sponsored dental plan;
- ☐ is not eligible to participate in the Company sponsored medical plan;
- ☐ is not eligible to participate in the Company sponsored dental plan;
- ☐ will be able to elect coverage as of ______________.
- ☐ no health coverage is offered by the employer.

Employer Signature	Date
Job Title	Business Phone

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