Spouse's Surcharge Waiver

*Please complete the following **ONLY** **if***

1. *You have elected coverage for your spouse under our Health Plan AND*
2. *You wish to avoid paying the spousal surcharge.*

2021 CALENDAR YEAR

Dear Employee:

If an employee of the City of Mason City chooses to enroll their spouse in our employer sponsored health benefits plan, that spouse must enroll in at least single health coverage through his/her employer, if available, to avoid being charged the spousal surcharge. If the spouse is not employed, is self-employed or the spouse's employer does not offer health coverage, the spousal surcharge does not apply. Therefore, we require your assistance in providing information that will allow us to determine your spouse's eligibility to avoid paying the spousal surcharge. This information is required at the time of enrollment. Any change of your spouse's employment status or insurance coverage during the calendar year will require you to report the status change to Human Resources within 31 days of the change, and may require completion of an updated form. Thank you for your assistance. If you have any questions, please contact Human Resources. **Failure to return this form will result in payment of the spousal surcharge**. **Falsification will result in disciplinary action.**

Respectfully,

Perry Buffington
Human Resources Director

EMPLOYEE: PLEASE COMPLETE BEFORE PROVIDING TO YOUR SPOUSE'S EMPLOYER:

City of Mason City's Employee's Name: _____

Employee's Signature: _____ Date: _____

Spouse's Name: _____

Spouse's Employer: _____

☐ Spouse is Not Employed Full Time

☐ Spouse is Self-Employed

☐ Spouse is either enrolled in health coverage through their employer or not eligible for their coverage

TO BE COMPLETED BY SPOUSE'S EMPLOYER (Please complete this form for the spouse listed above and return to them)

Name of Company: _____

Contact Person's Name: _____ Job Title: _____

Signature: _____ Date: _____

Please check one of the appropriate boxes below:

☐ The Spouse listed above is not eligible for health coverage through our company

☐ The Spouse listed above has declined health coverage through our company

☐ The Spouse listed above is enrolled in health coverage through our company

Provider: _____ Policy Number: _____ Effective Date: _____

This form must be submitted to the City of Mason City, Human Resources at the time of enrollment.