# Spousal Advantage Plan Enrollment Form

## EMPLOYER INFORMATION

Employer Name: Forest Lake Area Schools

***Please mail or e-mail completed form to:***

LeAnn Martinson
6100 N 210th St
Forest Lake, MN 55025

Email: lmartinson@flaschools.org
Telephone: 651-982-8113

**I am enrolling in the Spousal Advantage Plan for (Please check one):** ☐**Self Only** ☐**Self & Child(ren)** ☐**Child(ren) Only** ☐**Spouse Only** ☐**Self & Spouse** ☐**Self & Family** ☐**Spouse & Child(ren)**

## PARTICIPANT INFORMATION

| | | |
|---|---|---|
| Employee Name: | Birthdate: | Hire Date: |
| Social Security No: | Gender: ☐M ☐F | Date Eligible for Spousal Advantage Plan: |
| Home Street Address: | | |
| City: | State: | Zip Code: |
| Home Phone: | Work Phone: | Cell Phone: |
| Email Address: | | |

## SPOUSE INFORMATION

| | | |
|---|---|---|
| Spouse Name: | Birthdate: | Gender: ☐M ☐F |
| Social Security No: | Spouse's Employer: | |

Spouse's Pay Period for Health Premium Contribution: ☐Monthly ☐Semi-Monthly ☐Bi-Weekly ☐Weekly

*Please indicate if the medical deduction DOES NOT come out of every paycheck. Some may only be once a month or the first two pays of the month.*

Spouse's Health Premium Contribution per Pay Period: $ _____ ** **INCLUDE DOCUMENTATION, I.E. PAYSTUB OR BENEFIT STATEMENT**

Are Spouse's Health Premium Contribution / Deductions: ☐Before Taxes **(OR)** ☐After Taxes

* Contribution per pay period should include the cost for Medical only; Dental & Vision are not covered under this plan.
If submitting a spouse's paystub, please circle the contribution/deduction amount on the paystub.
* DO NOT BLACKOUT THE PAY PERIOD.
** Send a copy of your spouse's paystub that shows the NEW contribution/deduction as of the Spousal Advantage Plan effective date listed above. This amount should reflect the cost of adding you and/or any dependents to the spouse's plan.

*** If your spouse's plan has a High Deductible with a Health Savings Account (HSA), you are not eligible to participate in the Spousal Advantage Plan, unless the Employer allows your spouse to drop the HSA portion of the plan. Written documentation required. Also, if your primary health coverage is through Medicare, Tricare or Medicaid, you are not eligible for the Spousal Advantage Plan.**

## DEPENDENT INFORMATION: (Attach a separate sheet if additional space is needed for additional dependents)

| | | |
|---|---|---|
| Name: | Date of Birth: | Gender: ☐Male ☐Female |
| Social Security No: | | |
| Name: | Date of Birth: | Gender: ☐Male ☐Female |
| Social Security No: | | |
| Name: | Date of Birth: | Gender: ☐Male ☐Female |
| Social Security No: | | |

## PARTICIPANT AUTHORIZATION

I hereby authorize my employer to enroll me into the employer sponsored Spousal Advantage Plan. I agree to comply with the terms and conditions of the plan. You may be prosecuted for fraud for knowingly using health insurance benefits for which you are not eligible. It is YOUR responsibility to know when you or a family member is no longer eligible for Spousal Advantage Plan benefits. I understand that if the health premium contributions are deducted on an After-Tax Basis, this will result in all premium reimbursements being income tax free. However, if the contributions are on a Pre-Tax Basis, the premium reimbursements will be fully taxable. In either case, the deductible, co-pay and co-insurance reimbursements will remain tax free. **I further understand that if any current contributions are made to a Health Savings Account (HSA) by my spouse or his/her Employer, I am *not eligible* to participate in the Spousal Advantage Plan offered through my employer.**

**Employee Signature:** **Date:**