COLUMBUS STATE
COMMUNITY COLLEGE

MEDICAL PLAN WORKING SPOUSE/DOMESTIC PARTNER (SP/DP) PREMIUM AFFIDAVIT
This document is required when the SP/DP is covered under the College's Medical Plan

A working SP/DP surcharge will be added to your medical premium if your SP/DP is covered under the College's medical plan and your SP/DP is eligible for coverage through his/her employer but did not enroll in their employer coverage. The surcharge does not apply if both the EE and SP/DP are employed by Columbus State.

SP/DP Name: _____

- Is your SP/DP employed or self-employed? _____**YES** _____**NO**
- Is your SP/DP employed full-time (FT) or part-time (PT)? _____ **FT** _____**PT**
- If my SP/DP is not employed but obtains employment, I will notify the Benefit Team **immediately** _____ **Initial**
- Is your SP/DP retired or disabled? _____**YES** _____**NO**
- Do they have coverage as a retiree or disabled employee? _____**YES** _____**NO**

If the SP/DP is employed/self-employed, complete the REQUIRED INFORMATION below

SP/DP's Employer's name: _____

- Employer's full Address: _____
- Employer's Phone Number: _____
- Does the Employer **OFFER** a medical Plan? _____**YES** _____**NO**
- Did your SP/DP **ENROLL** in their employer medical plan? _____**YES** _____**NO**

If the SP/DP is enrolled in their employer medical coverage, complete the REQUIRED INFORMATION below

SP/DP's Medical Plan Name: _____

- SP/DP's Group #_____
- Effective date of coverage:_____

Include a copy of the SP/DP's Medical ID card with this affidavit.

_____My **SP/DP is enrolled in The College's medical plan** and **my SP/DP has medical coverage available through his/her employer** and **has not enrolled in their** medical plan. (**I understand the $50/$66.67 per pay premium** will be applied & authorize a deduction from my pay check on a pre-tax basis.)

If this form is not received by the Human Resources (HR) Department and your SP/DP is enrolled in the College's coverage**, you will be charged** the surcharge until this form is received. If your SP/DP **obtains or loses** health coverage through their employer, you are required to notify the College's HR Department within 31 days of such change. Failure to provide notification to HR in a timely manner will restrict you from making a change until the next annual open enrollment period.

My signature below indicates that the facts set forth on this form are true and complete to the best of my knowledge. I also understand that if the status of my SP/DP's medical coverage changes, it is my responsibility to notify the HR in writing within 31 days of such change.

Any false statements written on this form or on future forms as it relates to SP/DP medical coverage information shall be considered grounds for disciplinary action.

_____**Name (Please Print)**

_____**Name (Signature)**

_____**Employee #**

_____**Date**