MESSIAH UNIVERSITY

Spousal Surcharge Verification and Information Release Authorization Form

Section 1: Spousal Surcharge Verification Information – To be completed by Messiah University employee

Employee Name:	Spouse Name:	Employee Phone:

Is your spouse employed? **Yes** ☐ **No** ☐ *If you checked **No**, please sign and date Section 1 below and return to Human Resources. If you checked **Yes**, please continue to the next question.*

Is your spouse employed by Messiah University? **Yes** ☐ **No** ☐

If you checked **Yes,** then sign and date Section 1 and return the form to Human Resources.
If you checked **No**, sign and date Section 1, have your spouse sign and date Section 2, and have your spouse's employer complete Section 3. If your spouse is self-employed, please put "Self-Employed" by Company in the Section 3: Employer Verification section.

- **Failure to fully respond to this letter will result in a $60 per pay period spousal surcharge**
- **If your spouse is eligible for medical coverage through his/her employer and is enrolled in the Messiah University medical plan, you are required to pay a $60 spousal surcharge per pay period, and the surcharge** will be retroactive to your spouse's effective date of coverage or benefit eligibility date.
- **If your spouse is not eligible for medical coverage through his/her employer, the spousal surcharge will not apply.**

If you have questions regarding this form, please contact Jennifer Smithmyer, Employee Health and Wellness Coordinator at **(717) 796-1800 ext. 7086** or **jsmithmyer@messiah.edu**.

By signing below, I hereby certify and warrant to Messiah University that all information on this form is true, correct and current as of the date signed. I further understand if I knowingly submit false information I may be subject to disciplinary action, up to and including termination of employment and appropriate legal recourse. Furthermore, my signature authorizes Messiah University to verify any and all documents provided and may contact any institution or organization to verify the facts as stated herein.

Employee Signature: _____ Date: _____

Section 2: Information Release Authorization – To be completed by Messiah University employee's spouse

I authorize the use or disclosure of the requested information for the following purpose: Healthcare eligibility information provided to Messiah University will be used solely for determination of my eligibility for coverage under a Highmark Blue Shield plan sponsored by Messiah University. This authorization for release of the above information to Messiah University will expire following termination of coverage.

I understand that I am signing this authorization voluntarily. The consequences for my refusal to sign this authorization will be the application of the $60 per pay period surcharge for enrolling a spouse that is eligible for medical coverage through their employer.

Spouse Signature: _____ Date: _____

Section 3: Employer Verification – To be completed by spouse's employer ONLY.

Please provide the following information for your employee.

Is this employee **eligible** for medical coverage? **Yes** ☐ **No** ☐

If **Yes**, please indicate the date this employee became **eligible**: ____/____/____

Please note: Messiah University may contact you for a verbal confirmation of the eligibility. Non-responder or incomplete form will result in the $60.00 per pay period spousal surcharge for the employee's spouse. Thank you for your time and cooperation.

Company Name: _____

HR/Benefits Contact Name: _____

Contact Title: _____

Contact Signature & Date: _____

Contact Phone Number: _____

Once completed, please submit this form to Human Resources by mail or email this form to Jennifer Smithmyer, Employee Health and Wellness Coordinator at jsmithmyer@messiah.edu. You may also fax this form to Human Resources at (888) 295-9989.