SPOUSAL/DOMESTIC PARTNER ADDITIONAL CHARGE REMOVAL FORM

Employee Name: _____

Spouse/Domestic Partner Name: _____

A Spousal/Domestic Partner additional charge of $200 per month will be added to your monthly health plan rate if you have elected coverage for your spouse/domestic partner under the Columbus Metropolitan Library group health plan ("Plan") and your spouse/domestic partner is eligible for health coverage from their employer. Health care coverage is defined as employer sponsored health insurance, a healthcare sharing program or receiving a financial stipend for health insurance. This charge is in addition to the health plan rates published in the Annual Benefits Guide. You are responsible for paying this additional charge if you elect to cover your spouse or domestic partner on the Plan and they do not meet one of the three conditions detailed below:

☐ My spouse or domestic partner is employed but is not eligible for or not offered health coverage through their employer. (If your spouse or domestic partner is employed, attach a letter from their employer, on the employer's letterhead indicating that your spouse or domestic partner is not eligible for health insurance

☐ My spouse or domestic partner is self-employed or an independent contractor and does not have an employer that offers health coverage.

☐ My spouse or domestic partner is unemployed and not covered under any other employer-sponsored health coverage.

Important Note: The Spousal/Domestic Partner additional charge does not apply if your spouse/domestic partner is employed by CML.

If your spouse or domestic partner obtains or loses eligibility for health coverage from an employer, you agree to notify CML within 31 days of the change. You must also notify CML of a qualifying life event (such as divorce) within 31 days of the event.

This form may be submitted at any time during the plan year. The additional charge will be removed the month following submission of this form to Payroll & Benefits.

I do hereby attest that the information above is true and correct to the best of my knowledge I further acknowledge and understand that providing false information on this form is grounds for loss of group health plan coverage and/or disciplinary action.

_____

Employee Signature Date