City Of Sarasota
Human Resources/Benefits
111 S Orange Ave, Room 204
Sarasota FL 34236

2009 SPOUSAL/DOMESTIC PARTNER SURCHARGE FORM

You have chosen to cover your Spouse/Domestic Partner under your Benefit coverage with the City. Please provide the following information and return this form to the City Benefit Office. If you have any questions, please call 951-3631.

***IF YOUR SPOUSE/DOMESTIC PARTNER IS COVERED BY MEDICARE AS PRIMARY, THIS SURCHARGE WOULD NOT APPLY.**

Employee/Retiree Information:

Name: ______________________ Phone: ______________________

Address: ______________________ e mail: ______________________

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______________________ SS# ______________________

Date Of Birth: ______________________

Spouse/Domestic Partner Information: SS# ______________________

Name: ______________________ Date Of Birth: ______________________

Is your Spouse/Domestic Partner Employed:

☐ Yes — If **YES**, please supply the following employment information, sign and return to Human Resources.

☐ No — If **NO**, please sign the form and return to Human Resources.

Spouse/Domestic Partner Place of Employment:

Name: ______________________ Phone: ______________________

Address: ______________________

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Health Coverage Available? ☐ Yes ☐ No

If **Yes**, does your spouse/domestic partner participate in the available coverage? ☐ Yes ☐ No

Please Note:
(If your Spouse/Domestic Partner has Health coverage available and declines coverage at their place of work, an additional $50.00 per month will be added to your benefit costs)

Coverage Provider:
Name: ______________________ Phone: ______________________

Address: ______________________

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Signature: ______________________________________

Please Note: By this signature, I attest the information I provide here is true and accurate.