

**ACTIVE/RETIREE  
Spousal/Domestic Partner Surcharge Form**

EMPLOYEE NAME (LAST, FIRST):	EMPLOYEE DEPT:	EMPLOYEE PHONE #:	
ADDRESS (FULL ADDRESS):	CITY:	STATE:	ZIPCODE:

<b>SPOUSAL SURCHARGE</b>		
<b>If you are covering a spouse/domestic partner on your medical plan you must complete the following information</b>		

Spouse/Domestic Partner Name:	SS#	DATE OF BIRTH (MONTH, DAY, YEAR) / /
Is your Spouse/Domestic Partner Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If <b>Yes</b> , Provide Name of Spouse/Domestic Partner's Employer: _____	Address of Employer: _____ _____
If <b>Yes</b> , Is medical coverage available?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If <b>Yes</b> , Does your Spouse/Domestic Partner participate in the available coverage?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If <b>Yes</b> ,	Provide Health Coverage Name:	
Health Coverage Address:		_____ _____ _____
		Phone: _____

By my signature, I attest the information I provide here is true and accurate.	
Employee Signature: _____	
Date: _____	