AdvocateAuroraHealth

Employer/Plan Sponsor Certification
2020 Spousal Surcharge Waiver Form

Only complete this form if you enroll your spouse/domestic partner in an Advocate Aurora Health medical plan for 2020.

This form must be completed in full and returned within 45 days of enrolling your spouse/partner into benefits in order to avoid the surcharge.

Advocate Aurora Team Member/Spouse Section

☐ My spouse/domestic partner is employed outside of Advocate Aurora Health – ***Advocate Aurora Team Member/Spouse AND Employer Sections MUST be completed***

Name of Team Member (please print):_____ ID Number:_____

Name of Spouse/Partner (please print):_____

Team Member Signature: _____ Date:_____

Spouse/Partner Signature: _____ Date:_____

Employer Section

You are receiving this form because you employ and/or sponsor the group medical plan of the spouse/partner of an Advocate Aurora Health team member. Advocate Aurora Health's group health plan requires that a determination be made concerning a spouse/partner's eligibility for other medical coverage. The information you provide below will help Advocate Aurora Health make this determination. We appreciate your time and assistance in this matter. If you have any questions, you may contact Advocate Aurora Health at (262) 957-8300. Thank you for providing this completed form.

The spouse/partner identified above is employed at your company. ***Please check the option that describes his/her eligibility for benefits:***

- ☐ Group medical coverage is offered to our employees, and this employee is currently enrolled. Coverage effective date:_____
- ☐ Employee is eligible for group medical coverage, but has chosen not to enroll.
- ☐ Employee is not eligible for group medical coverage.
- ☐ Group medical coverage is not offered by the employer.
- ☐ Employee will be eligible and able to enroll in group medical coverage at a future date (please provide date):_____

Signature of Employer/Plan Sponsor Representative

Name of person completing this form (please print):_____

Signature: _____ Date:_____

Title & Company Name: _____

Phone Number: ( ) _____-_____ Email Address: _____

Team Member: Please create a case in *My HR Navigator* by logging onto *Caregiver Connect* and selecting the *My HR Navigator Quick Link*. Click on *Create Case* under the *Case Information* heading. Utilize the following: **Case Topic**-My Benefits, **Sub Topic**-Medical, **Detail**-Spousal Surcharge-Submit Form. Once your case has been created, scan and attach the completed form to your case, or fax your completed form to 262-957-8301. If you fax the form, please write your case number on the fax cover sheet. ***Deadline for receipt of completed form is 45 days after you enroll your spouse/partner in medical benefits.***

Employer: Fax completed form to 262-957-8301.