FOXDALE VILLAGE
DECLARATION OF SPOUSE / PARTNER HEALTH INSURANCE COVERAGE

This Declaration of Spouse / Partner Health Insurance Coverage must be completed by all participants in the group health insurance plan offered by Foxdale Village who elect to cover a spouse / partner under the health insurance plan.

A spouse / partner of an employee participant enrolled in the Foxdale Village health insurance plan is not eligible for coverage in the Foxdale Village if that spouse / partner is eligible for coverage at his/her own place of employment where that employer of such spouse / partner pays any portion of the premium cost.

Section I:

Your Name: _____

Your Spouse / Partner's Name: _____

Section II: (Please circle "yes" or "no")

a.) Is your spouse employed? Yes No

If yes, are they full-time? Yes No

If yes, provide name of employer: _____

Please provide phone number of employer: _____

If no, please proceed to Section III.

b.) Does your spouse / partner have access to an employer-sponsored health insurance plan for which his / her employer pays a portion of the premium cost?

Yes No

If "yes," please list the name of the health insurance plan offering the plan:

_____

If "no," are you electing coverage for your spouse / partner under the Foxdale Village health plan?

Yes No

Section III:

I declare that the foregoing information is true and accurate to the best of my knowledge,
information and belief. I understand that Foxdale Village reserves the right to suspend or terminate my group health insurance coverage and / or the group health insurance coverage of my spouse / partner and/or eligible children (if applicable) if Foxdale Village concludes that I have provided false or misleading information in this Declaration.

I understand that if my spouse / partner's employer offers group health insurance coverage for which it pays any portion of the premium, my spouse / partner must enroll in his/her employer's plan. I understand that if my spouse / partner does not so enroll, he or she is ineligible to be covered as a dependent in the Foxdale Village health insurance plan.

If the status of my spouse / partner's employment or eligibility for coverage under his / her group health insurance plan should change, I am required to notify Human Resources and complete an updated Declaration of Spouse / Partner Coverage document.

_____
Printed Name

_____
Signature

_____
Date

Please complete this form and return to Human Resources as soon as possible.

Contact Saprina Harter (814) 272-2111 or saprinah@foxdalevillage.org with questions.

Thank you for your prompt cooperation.