SPOUSAL SURCHARGE WAIVER FORM

If you enroll your spouse/domestic partner in one of the American Lung Association sponsored medical plans, you must complete this **Waiver Form** and return it to Human Resources at **Askhr@lung.org.** If you are **NOT** enrolling your spouse/domestic partner in ALA's medical plan, this form is not needed.

A $50.00 semi-monthly spousal surcharge***** will be added to your premium if you have elected coverage for your spouse/domestic partner and your spouse/domestic partner is eligible for coverage through his/her employer.

The ALA will automatically apply a spousal surcharge, in the amount of $50.00 per pay period, if you do not complete and return the Waiver Form after completing your online enrollment. No refunds or retroactive credits will be issued for forms submitted late. The surcharge will be discontinued the 1st of the month following submission of the waiver form when the surcharge is not applicable.

Employee's Name: _____

Spouse Name: _____

Please check appropriate box, sign and date this form:

☐ My spouse/domestic partner is not employed or is self-employed and does not have access to an employer-sponsored health plan. (Spousal surcharge does not apply.)

☐ My spouse/domestic partner is employed but is not eligible for an employer-sponsored health plan and is enrolled in ALA's plan. (Spousal surcharge does not apply.)

☐ My spouse/domestic partner has access to an employer-sponsored health plan but has elected to enroll in ALA's plan.

I understand the $50.00 semi-monthly premium surcharge will be applied & I authorize a deduction from my paycheck on an after-tax basis.

CERTIFICATION:

- I certify that the information provided on this form is true and correct to the best of my knowledge.
- I will notify Human Resource within 30 days if my spouse/domestic partner gains or loses other employer medical coverage (a qualifying event) and submit a revised Waiver Form to HR within 30 days of the event.
- I further understand a spousal surcharge may be terminated at the first of the month following timely notification. Spousal surcharge refunds or late notifications are not permitted.
- I acknowledge that any false statements written on this form or on future forms may lead to disciplinary action up to and including termination of employment.

Signature: _____ **Date:** _____

NOTE: *This surcharge is in addition to the normal semi-monthly cost for the medical option you select. Please note that this fee is subject to change on an annual basis.