Penn Medicine
Lancaster General Health

CORESOURCE
A Trustmark Company

Spouse Eligibility Form
LG Health/Penn Medicine

(Only Applicable to Health Benefits Program Enrollment)

Please note that this form does not need to be completed if the spouse is enrolled in LG Health/Penn Medicine dental and/or vision coverage only.

LG Health/Penn Medicine provides primary medical coverage for working spouses of LG Health/Penn Medicine employees, provided that the spouse is not offered medical coverage by his/her employer, ***or*** the spouse is required to contribute 50% or more of the total cost of the employer's premium for coverage from his/her employer. LG Health/Penn Medicine benefits may be elected as secondary coverage, if the provisions outlined above are not applicable and the spouse meets LG Health/Penn Medicine's eligibility criteria.
This form must be completed and returned within 3 weeks of completing your enrollment. If your spouse is employed, he or she must have Section 2 completed by their employer's Human Resources Representative. Section 2 does not require completion if your spouse is employed by LG Health/Penn Medicine. Please retain a copy of this completed form for your records.

Section 1 – LG Health/Penn Medicine Employee
This section must be completed by the LG Health/Penn Medicine Employee

Employee Name:
Spouse Name:
My spouse works? ☐ No (Sign, date, and return this form)
My spouse works? ☐ Yes (Proceed to Section 2)
My spouse is self-employed? ☐ Yes **(Note: work related injuries or illnesses are not covered)**
Name of Spouse's Employer:
Address of Spouse's Employer:

I solemnly affirm that the information provided above is true, accurate, and complete. I understand that providing false information may result in health coverage cancellation and/or disciplinary action in accordance with the provisions of my health benefits program and/or LG Health/Penn Medicine policies.

_____ _____
Employee Signature (If Electronic Signature: My typed name above shall have the same force and effect as my written signature) Date

Section 2 – Spouse of LG Health/Penn Medicine Employee
This section must be completed by an authorized Human Resources Representative of the above named Spouse's Employer:

1. Is medical coverage available to your employee? ☐ Yes ☐ No
2. Does your employee contribute 50% or more of the total cost of the employer's premium for medical coverage? Yes ☐ No ☐
3. Is your employee enrolled in the available medical coverage? ☐ Yes ☐ No
Name & Title of HR Representative completing this Form (please print):
Telephone # & e-mail Address of HR Representative Completing this Form (please print):

_____ _____
Human Resources Representative Signature Date