Spouse Eligibility Form

This form must be completed if your spouse is enrolled in a health insurance plan through LG Health.

LG Health provides primary medical coverage for working spouses of LG Health 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. LG Health benefits may be elected as secondary coverage if the provisions outlined above are not applicable and the spouse meets LG Health 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 also employed by LG Health.

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

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

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 policies.

____ ____________

Employee Signature Date

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

Section 2 – Spouse of LG Health 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

Phone: 717-544-4915 ● *Fax:* 717-544-1351 ● *Email:* LGH Benefits team at lgh-benefits@pennmedicine.upenn.edu