Penn Medicine
Lancaster General Health

# Spouse Eligibility Form

## This form must be completed if opting to enroll your spouse 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. If this plan is secondary coverage for your spouse please make sure to update the Other Insurance information. This can be done via the Capital Blue Cross My Health Toolkit *(Select Benefits → Other Health Insurance)*.

This form must be completed and uploaded to the Dependent Event in Workday. 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

**To be completed by the LG Health Employee**

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| **Employee Name:** |
| **Spouse Name:** |
| **My spouse works:** ☐ Yes (Complete information below and proceed to Section 2)<br>☐ No (Sign, date, and return this form) |
| **Name of Spouse's Employer:** |
| **Address of Spouse's Employer:** |
| **My spouse is self-employed:** ☐ Yes (Sign, date, and return this form)<br>**Note: work related injuries or illnesses are not covered** |
| **Coverage Requested for Spouse:** ☐ Medical & Prescription ☐ Dental ☐ Vision |

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

**To be completed by an authorized Human Resources Representative of the above named Spouse's Employer**

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| **1. Is medical coverage available to your employee?** ☐ Yes ☐ No (Sign, date, and return this form) |
| **2. Is your employee enrolled in the available medical coverage?** ☐ Yes ☐ No |
| **3. Does your medical plan require employees to contribute 50% or more of the total cost of the employer's premium for 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