Washington University
SPOUSE/DOMESTIC PARTNER
PREMIUM SURCHARGE CHANGE FORM

Complete this form if your spouse or domestic partner has experienced a change in employment that affects whether or not you should be charged the Health Premium Surcharge.

Employee Name- please print	**Employee ID**	**Campus Phone No.**

Instructions: Answer the yes/no questions in the box, then check the appropriate explanation below.

Is your Spouse/Domestic Partner employed outside of Washington University on a full-time basis?	Yes ☐	No ☐
If yes, does your Spouse/Domestic Partner have health insurance available through his or her place of employment?	Yes ☐	No ☐
Do you want to cover your Spouse/Domestic Partner under the University's health plan?	Yes ☐	No ☐

☐ My spouse/domestic partner's work status has changed within the last 31 days. I am no longer subject to the premium surcharge. Please submit proof of change with this form.

EFFECTIVE DATE OF CHANGE: _____

☐ My spouse/domestic partner's work status has changed within the last 31 days making me subject to the premium surcharge.

EFFECTIVE DATE OF CHANGE: _____

My signature on this form indicates to Washington University that all information is true, correct and current as of the date signed. I agree to provide supporting documentation upon the request of Washington University. I understand if I knowingly submit false information, my health/dental coverage may be terminated and I may be subject to disciplinary action up to and including termination of employment.

Employee Signature	***Date***

Send completed form and supporting documents to:

Medical School Employees: CB 8002 or fax to (314)362-2500
Danforth Employees: Kim Olivastro, CB 1190 or fax to (314) 935-8198