



B-W SPOUSAL/DOMESTIC PARTNER HEALTH CARE ELIGIBILITY DETERMINATION FORM

The purpose of this form is to determine if the spouse/domestic partner of a Baldwin-Wallace College employee is eligible to be covered or continued to be covered by the College's health care plan. If a spouse/domestic partner of a B-W employee has access to any employer-sponsored health care plan*, or to any employer-sponsored retiree or disability health care plan*, s/he is not eligible to be covered under any Baldwin-Wallace College health care plan. This form is to be completed by the employee.

Employee Name (Please Print): _____

Name of Spouse/Domestic Partner (Please Print) _____

1. Does your spouse/domestic partner have access to an employer sponsored health care plan or to an employer sponsored retiree health care plan?

_____Yes _____No

If you answered **No**, your spouse/domestic partner is eligible for coverage under B-W's health care plan.

2. Please complete this question only if you answered Yes to question 1 and your spouse/domestic partner is Not currently on or eligible for a retiree health care plan. Does your spouse/domestic partner work full-time?

_____Yes _____No

If you answered **Yes to both questions 1 AND 2**, your spouse/domestic partner is NOT eligible for coverage under B-W's health care plan. **If you answered No to question 2**, your spouse/domestic partner may be eligible based on his or her part-time work schedule. A letter from spouse/domestic partner's employer providing hours worked per week will be needed to make a final determination.

I hereby attest that the information provided on this form is complete and truthful. I understand that any false or incomplete information that I provide could lead to the immediate termination of B-W health care benefits for me and my dependents. I understand that B-W may request additional supporting documentation at any time and that in the event of such a request, I will promptly provide such documentation. If I do not complete and submit this form, my spouse/domestic partner will be dropped from coverage **effective with the start of the next benefit year, January 1st**. I further agree to inform Human Resources within 30 days of any employment status change for my spouse/domestic partner that no longer makes him/her eligible for coverage under B-W's health care plan. I understand that failure to do so could lead to loss of eligibility for B-W health care benefits for me and my dependents.

Employee Signature

Date

* B-W's plan is not considered an employer sponsored health care plan. Other employer sponsored health care plans include plans from current and former private and public employers, including retiree health care plans and health care plans that cover disabled employees.