Kenai Peninsula Borough School District Health Care Plan

Spousal Surcharge Affidavit

1. EMPLOYEE INFORMATION			
EMPLOYEE NAME:			**Employee#**
Social Security Number:			**Date of Birth:**
Mailing Address:			**Sex:** ❑ M ❑ F
City:	**State:**	**Zip:**	

2. SPOUSE INFORMATION

This section must be completed if you are enrolling your spouse. If you are married but not enrolling your spouse, this form is not required.

1. **Spouse's name:** _____
2. **Is your spouse employed as of January 1,2025?**
   - ❑ **YES**
   - ❑ **NO** (If no, please skip to section 3)
3. ***Is your spouse eligible for health benefits through their employer as of January 1,2025?**
   - ❑ **YES**
   - ❑ **NO** (If no, please skip to section 3)
4. **Is your spouse enrolled in health benefits through their employer as of January 1,2025?**
   - ❑ **YES**
   - ❑ **NO**
5. **If you responded YES to number 4, is your spouse's coverage a reduced benefit plan that shifts the majority of the cost of medical claims to the Secondary Plan?**
   - ❑ **YES**
   - ❑ **NO**

You are subject to a $200 per month surcharge ($240 prorated for 9-month employees through 6/30/2025) if your spouse declines health coverage available through their employer, or if your spouse enrolls in a reduced benefit plan which shifts primary coverage to the Kenai Peninsula Borough School District Health Plan.

❑ **YES,** I understand that I am subject to a $200 monthly surcharge for enrolling my spouse under the Kenai Peninsula Borough School District Health Plan when they are eligible, but not enrolled for coverage through their employer or my spouse is enrolled with their employer, but the Kenai Peninsula Borough School District Health Plan will be their Primary plan.

**Your spouse is considered eligible if their job position entitles them to health benefits through their employer, even if they declined coverage or failed to enroll timely and therefore are without health coverage through their employer.*

I understand that if my spouse's group health insurance status changes, it is my responsibility to notify Employee Benefits Manager in writing within 31 days of such change. Any false statements written on this form or on future forms as it relates to spousal health information shall be considered grounds for disciplinary action.

3. SIGNATURE

I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted. I UNDERSTAND THAT MISSTATEMENT, OMISSION OF INFORMATION OR FAILURE TO DISCLOSE ANY INFORMATION MAY BE USED AS A BASIS FOR RESCISSION OF COVERAGE FOR ME AND FOR MY DEPENDENTS, AND THAT I WILL BE GUILTY OF INSURANCE FRAUD. I authorize deductions, if any, from any earnings toward the cost of the coverage. A copy of this authorization shall be as valid as the original.

Sign Here → _____ _____ _____

Employee's Signature *Print Name* *Date*

THIS SECTION TO BE COMPLETED BY EMPLOYER

Exact date of full-time employment:	**Effective Date:**	**Date Processed:**	
Month Day Year	Month Day Year	Month Day Year	Plan Administrator