



Employee's Name Printed: _____

Work Place/Region: _____

Schools please select: K-8 OR 9-12

SOUTHERN CALIFORNIA CONFERENCE

SPOUSE'S HEALTH CARE APPLICATION FORM

(Required form for all married employees)

January 1–December 31, 2019

If you are married your spouse may apply for coverage, as your dependent, under the same SCC Blue Shield health care plan which you are enrolled in. If your spouse is not eligible for other employer-provided health coverage, he/she may be eligible to participate in the SCC healthcare plan. The monthly contribution will be deducted from your paycheck. Please select the appropriate choice below and provide the requested information:

- 1. My spouse is not employed and is applying for participation in my SCC Blue Shield health plan.
2. My spouse is employed and has his/her own health plan. I understand that he/she is NOT eligible for coverage under my SCC health plan.
3. My spouse is employed but his/her gross annual earnings* are less than \$52,000 per year and he/she is not eligible for any employer-sponsored health coverage. I apply for SCC healthcare and request coverage. I will provide a copy of my spouses 2018 W-2 or 1040 form and a letter from his/her employer verifying that he/she is not offered medical benefits. SCC HR must receive these on or before February 28, 2019.
4. My spouse is employed and his/her gross annual earnings* are \$52,000 or more per year and he/she is not eligible for any employer-sponsored health coverage. He/she is ineligible for subsidized SCC Healthcare coverage. My spouse is requesting to buy in to the SCC Healthcare plan at a cost of \$620.00 per month for PPO plan / \$660.00 per month for HMO plan which will be withheld from my SCC paycheck. I am providing a letter from his/her employer verifying that he/she is not eligible for health insurance offered by his/her employer. I acknowledge that this is an accommodation and that I have no "right" to benefits and denial of this accommodation is at the sole discretion of SCC.
5. My spouse is employed by SCC and is eligible for health care coverage by SCC. He/she is aware that he/she can have his/her own health plan independent of me but chooses to be covered under my plan as a dependent. If we have children, we must choose the same health plan.

I certify that the above statements and supporting information are true, complete and correct. I also agree to immediately notify the SCC Human Resources Department of any changes that may affect my spouse's eligibility status.

Signature of Employee

Date

NOTE: If the Conference employee is married, this form must be returned.

EMPLOYEE: If applying for spouse buy-in, employee must sign below:

I authorize SCC to withhold \$680.00 for PPO or \$750.00 for HMO per month from my paycheck.

Employee's signature required, if spouse is buying in

Date

If spouse is applying for SCC coverage he/she acknowledges SCC right to verify spousal income.

Signature of Spouse

Date