2024 SPOUSE MEDICAL INSURANCE COVERAGE STATEMENT

Prevea Health's medical plan contains a Spouse Medical Insurance Coverage Statement, which requires that an employee's spouse either take at least single medical coverage through his/her employer to serve as his/her primary insurance coverage or pay an additional fee ($57.69 per pay period) for the spouse to enroll in Prevea's medical coverage as primary coverage. Only **complete this form if you enroll your spouse in a Prevea Health medical plan for 2024.** This form must be completed in full and returned within 30 days of enrollment into the medical insurance benefit in order to avoid the surcharge.

Prevea Employee: Please complete Section I. Your spouse's employer (if applicable) needs to complete Section II.

Section I. This Section must be completed by the **Prevea employee**

Employee Name (Please Print): _____

Employee Signature: _____ Date: _____

Spouse Name (Please Print): _____

Spouse Signature: _____ Date: _____

Is your spouse retired? ☐ Yes ☐ No **Is your spouse employed**? ☐ Yes ☐ No

Is your spouse employed by Prevea? If "Yes" skip Employer Section below. ☐ Yes ☐ No

Section II. This Section must be completed by **Spouse's employer**

You are receiving this form because you employ and/or sponsor the group medical plan of the spouse of a Prevea Health employee. Prevea Health's group medical plan requires that a determination be made concerning a spouse's eligibility for other medical coverage. The information you provide below will help Prevea Health make this determination. We appreciate your time and assistance in this matter. If you have any questions, you may contact Marcy Clark (Manager of Benefits) at 920-272-1163. Thank you for providing this completed form.

Please select the appropriate response:

- ☐ Group Medical coverage is offered to our employees, and this employee is currently enrolled. Coverage, effective date: _____.
- ☐ Group medical coverage is not offered by the employer.
- ☐ Employee is not eligible for group medical coverage.
- ☐ Employee is eligible for group medical coverage but has chosen not to enroll.
- ☐ Employee is part-time and is required to pay a higher monthly part-time cost for group medical coverage compared to company full-time employees
- ☐ Employee will be eligible and able to enroll in group medical coverage at a future date (please provide date): _____.

Signature of **Employer/Plan Sponsor Representative**

Name of Person completing this form (please print): _____

Signature: _____

Title & Company Name: _____

Phone Number: (___) ____-_____ Email Address: _____

Upon Completion of this form, please return to:

Prevea Health
Attn: Human Resources- Benefits
PO BOX 19070
Green Bay, WI 54307-9070

FAX: Attn: HR- Benefits
920.496.4717