SAN ANTONIO WATER SYSTEM

2017 Employed Spouse Premium Surcharge Waiver Form

The Employed Spouse Premium Surcharge is a $100 monthly surcharge ($50.00 per pay period) that is required above and beyond the regular employee medical contribution (premium) rate for SAWS active and pre-65 retiree medical plans. It is intended to encourage those spouses who have access to alternative medical coverage to move from the SAWS sponsored medical plan to his or her own employer's plan. If your spouse does not have access to other available coverage, you may be eligible to waive this surcharge (see criteria below).

TO REQUEST WAIVING THE SURCHARGE, PLEASE COMPLETE AND SUBMIT THIS WAIVER FORM ALONG WITH REQUIRED DOCUMENTATION (AS LISTED BELOW) WITH YOUR ENROLLMENT FORM.

SECTION 1: AFFIDAVIT TO WAIVE THE 2017 EMPLOYED SPOUSE PREMIUM SURCHARGE

I am hereby requesting to have the Employed Spouse Premium Surcharge **WAIVED** because I meet one of the following criteria and I understand I must provide the following documentation, depending on my spouse's situation, as stated below and that this form must be updated and re-submitted if my spouse's status changes.

Please select ONE of the following criteria below that applies to your spouse (check one box only):	**You Must Submit the Following Documentation for the criteria you meet for the Spousal Surcharge Waiver:**
☐ My spouse is not presently employed and does not have access to any other medical coverage	✓ This Waiver Form only, unless this event occurs after your initial enrollment period, in which case provide a letter from the former employer
☐ My spouse is self-employed without access to other medical coverage	✓ This Waiver Form only
☐ My spouse is covered by Medicare Part A or CHAMPUS insurance and enrolled in a SAWS medical plan	✓ This Waiver Form **AND** a copy of his or her Medicare or CHAMPUS ID
☐ My Spouse is employed, but his or her employer does not offer medical coverage or is not eligible for medical coverage by his or her employer	✓ This Waiver Form **AND** your spouse's employer must complete Section 2, on the reverse side of this form

Note: Spousal Surcharge begins the first pay period your medical plan enrollment is effective. THERE IS NO RETROACTIVE REIMBURSEMENT OF THE SURCHARGE.

EMPLOYEE CERTIFICATION

I certify that the information I am providing is true and accurate to the best of my knowledge. I understand that intentional misrepresentation of the facts above is considered insurance fraud and may result in recoupment of any and all benefits improperly paid on my behalf by SAWS self-funded medical plans AND may lead to disciplinary action, up to and including employment termination.

Printed Name of SAWS Employee/Retiree **Employee ID#**

Signature of SAWS Employee/Retiree **Date**

Printed Name of Spouse

Signature of Spouse **Date**

NOTE – WAIVER FORMS DUE AT TIME OF ENROLLMENT

Submit your form and documentation to the attention of SAWS HR Benefits Office:
MAIL: P.O. BOX 2449, San Antonio, TX 78298
SCAN AND EMAIL: Michelle.Kadin@saws.org
FAX: 210-233-4421
PHONE: 210-233-2025

NOTE: This form must be updated and re-submitted if your spouse's status changes.

See reverse for Spouse Benefits Eligibility Verification section

SAN ANTONIO WATER SYSTEM

2017 Spouse Benefits Eligibility Verification Form

SECTION 2: SPOUSE EMPLOYER CERTIFICATION

If your spouse is employed, but his or her employer does not offer medical coverage or he or she is not eligible for coverage, you may be eligible to waive this surcharge. This page must be completed by your spouse's employer, if he or she is not eligible for the employer's coverage.

Instructions to employer: Please certify that the spouse named herein is employed by your company, and indicate his or her medical benefits eligibility with your company. If this member will be eligible for medical benefits at a future date, please provide the date his or her coverage may begin. Please contact Michelle Kadin, Benefits Analyst at San Antonio Water System, with any questions, at 210-233-3306.

I hereby certify that _____ is employed by
Spouse of SAWS Employee

_____.
Company name

I further certify that:

☐ This employer does not provide medical coverage to employees.

OR

☐ The employee named above is not eligible for employer medical coverage because:

_____

Reason for ineligibility. ***If employee will be eligible in future, please provide date of future eligibility.***

_____

Name and Title of Benefits/HR Administrator (please print)

_____

Phone number and email address of Benefits/HR Administrator

_____

Benefits/HR Administrator Signature Date Signed

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