Baldwin Wallace University Spouse/Domestic Partner* Health Care Eligibility

If the spouse of a BW employee has access to an employer-sponsored health care plan, or to an employer-sponsored retirement/disability health care plan, s/he is not eligible for coverage under BW's health care plan.

Section I -To be completed by BW employee

Name (please print) _____ SSN (last 4 digits) _____

Name of spouse/domestic partner _____

*Domestic partner benefits are offered to those employees and domestic partners who were grandfathered as of January 31, 2016.

Spouse employment status (check one)

☐ Unemployed

☐ Employed – if this box is checked, Section II is to be completed by spouse's employer

☐ Self-employed

☐ Retired – not eligible for retiree health care

☐ Retired -- eligible for employer-sponsored health care

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 BWU health care benefits for me and my dependents. I understand that BWU 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 by the annual open enrollment deadline, my spouse/domestic partner will be dropped from coverage effective with the start of the next benefit year, January 1. 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 BWU's health care plan. I understand that failure to do so could lead to loss of eligibility for BWU health care benefits for me and my dependents.

Employee Signature _____ Date _____

Section II- To be completed by spouse's employer

Baldwin Wallace University requests the following information from the spouse/domestic partner's employer to evaluate eligibility for benefits under the BW health care plan. Please answer a few brief questions.

Employee name _____ SSN (last 4 digits) _____
(Spouse or domestic partner of Baldwin Wallace University Employee)

Do you offer health care coverage to your employees? ☐Yes ☐No

Is this employee eligible for health care coverage under your plan? ☐Yes ☐No

Do you pay a portion of the employee's premium? ☐Yes ☐No

If no longer employed, please provide the date health care coverage terminated. _____

Form completed by:

Name/Title (Please print) _____ Date _____

Employer/Company Name _____

Phone (_____) _____

Please email completed form to hr@bw.edu