

**CARILION CLINIC EMPLOYEE MEDICAL PLAN
REQUEST FOR WORKING SPOUSE/DOMESTIC PARTNER PREMIUM WAIVER
EMPLOYER STATEMENT OF COVERAGE**

Section 1: TO BE COMPLETED BY CARILION CLINIC EMPLOYEE (please print)	
Employee Name	Carilion Badge #
Employee Email Address	Employee Phone #
Spouse/Domestic Partner Name	Spouse DOB
Is your spouse/domestic partner employed by Carilion Clinic? ☐ YES ☐ NO	If yes, Spouse/Domestic Partner's Carilion Clinic Badge #

By signing below, I acknowledge the information on this form is accurate to the best of my knowledge. I agree to inform Carilion Clinic Human Resources immediately if my spouse/domestic partner becomes eligible for medical coverage through his/her employer. I also understand that falsification of information and documents is subject to disciplinary action, up to and including termination of employment.

Employee Signature

Date

Spouse/Domestic Partner Signature

Date

Section 2: TO BE COMPLETED BY SPOUSE'S/DOMESTIC PARTNER'S EMPLOYER	
Instructions to employer: Please certify the spouse or domestic partner named above is employed by your company and indicate his or her eligibility for medical benefits.	
I certify that the spouse or domestic partner named above is employed by our company and is not eligible for medical benefits because:	
☐ This employer does not provide medical coverage to employees.	
OR	
☐ The employee named as spouse or domestic partner above is not eligible for medical coverage through this employer due to employment status or hours worked.	
Name of Benefits/HR Administrator (please print)	Contact phone number for Benefits/HR Administrator
Title of Benefits/HR Administrator	Contact email address for Benefits/HR Administrator
Benefits/HR Administrator Signature	Date Signed

CARILION CLINIC HUMAN RESOURCES USE ONLY	
WSP waived? ☐ YES ☐ NO	Effective Date
HR Initial	Date