SPOUSE MEDICAL COVERAGE STATEMENT

If an employee's spouse is eligible for medical coverage through his/her employer but employee elects to enroll their spouse in the Vernon medical plan, the Vernon medical plan requires that the employee pay a $125 monthly surcharge, which is added to the employee's premium for medical coverage.

Vernon Employee: Please complete Part I. Your spouse's employer (if applicable) completes Part II.

PART I. *(To be completed by Vernon Employee.)*

Name: _____ Employee Social Security #: XXX-XX-_____
(Please print)

Spouse Name: _____ Spouse Social Security #: XXX-XX-_____
(Please print)

___My spouse is unemployed at this time.
___My spouse is retired.
___My spouse is self-employed and doesn't offer group coverage to his/her employees.
___My spouse is a Vernon employee.
___My spouse is currently employed, see Part II below.

I hereby certify that the information contained on this form is true and correct. I understand that The Vernon Company reserves the right to verify the information provided on this form by contacting my spouse's employer. I also understand that if I enroll my spouse in the Vernon medical plan and my spouse has health coverage available through his/her employer, a $125 monthly premium surcharge will apply. I authorize a deduction from my paycheck on a pre-tax basis to cover this spousal surcharge. I also understand that if my spouse becomes eligible for medical coverage from his/her employer during the plan year, I must notify Vernon Human Resources of this change within 30 days.

Employee Signature: _____ *Date:* _____

PART II. *(To be completed by spouse's employer, if applicable.)*

Company Name: _____

Please check all that apply:
___The above named "spouse" is employed at this company.
___The above named "spouse" is eligible for medical coverage, and is currently enrolled in employer's medical insurance.
___The above named "spouse" is eligible for medical coverage but is not currently enrolled in employer's medical insurance.
___The above named "spouse" is not eligible for medical coverage at this time because: *(Please state reason or attach letter.)*_____
Date employee may apply for coverage again: _____
___No health insurance coverage is offered by employer.

Signature of "spouse" employer *(Must be completed if Part II. was completed.)*

Name of person completing this form: _____
(Please print)

Signed: _____ Date: _____
Title: _____ Phone Number: _____
Email Address: _____

THIS FORM MAY BE SENT, EMAILED OR FAXED TOTHE VERNON COMPANY HR DEPARMENT:

Heather Van Dusseldorp (heatherv@vernoncompany.com) OR Fax Number: (641)791-8650.

Please note: If a form is not returned by Friday March 8, 2024, your spouse will NOT be on the Vernon medical plan for the 2024 plan year.