

**Liberty Health**  
2334 S 41<sup>st</sup> Street Wilmington, NC 28403  
P: 910.332.1922      F: 910.815.4356

**\*\*\* COMPLETE ONLY IF COVERING SPOUSE FOR HEALTH INSURANCE \*\*\***  
**Spouse Eligibility Requirements**

Dependent spouses who have access to health insurance coverage through their own employment but who choose to decline that coverage and be covered under the Liberty group health plan will be subject to a bi-weekly premium surcharge of \$200. This will be deducted from the employee's paycheck on a pre-tax basis.

Like many other employers, we are initiating this change to minimize costs to plan participants. Because our insurance plan is self-funded, the premiums paid cover the cost of claims. Liberty Health pays a significant portion of the premium costs (as do most companies), and our employees make up the difference. Premiums are based on the claims submitted so we are essentially subsidizing other companies' employees who choose to be on our plan instead of selecting their own.

If you have a spouse that you would like to enroll, please check the box below that applies to you. If your spouse's coverage situation changes during the year, you must notify Human Resources within 30 days of the event. Your signature below is an acknowledgment that you have accurately described your spouse's current situation with regard to other health plan coverage. Any falsification of this document may subject you to disciplinary action or penalty, up to and including discharge.

- Option #1:** My spouse has access to other health insurance coverage through his/her employment or self-employment. I decline that coverage and will continue my spouse's coverage through the Liberty Group health plan. I understand that **I will pay a bi-weekly premium surcharge of \$200 to keep my spouse enrolled in this plan.** I authorize Liberty to deduct the calculated surcharge as part of my bi-weekly benefit deduction on a pre-tax basis from my compensation.
- Option #2:** My spouse does not have access to other health insurance coverage through his/her employment or self-employment or is not currently employed or self-employed. I choose to continue my spouse's coverage through the Liberty Group health plan. I understand that if my spouse becomes eligible for health insurance coverage in the future, I must notify Liberty within 30 days.
- Option #3:** My spouse has access to other health coverage through his/her employment or self-employment and is enrolled in that plan. I choose to enroll him/her in the Liberty group health plan as secondary coverage with no surcharge. Please list plan names & numbers:

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**