

**IDENTIFICATION FORM TO ENROLL OR WAIVE EMPLOYEE'S SPOUSE AND/OR
DEPENDENT IN CITY OF XENIA'S HEALTH PLAN**

Employee Name _____ Date _____

Department _____ Phone # _____

Check the box that best describes your situation:

- I have no dependents and/or spouse;
- My dependent and/or spouse is employed by City of Xenia;
- My dependent and/or spouse is not eligible for any medical coverage through his/her employer; or
- My dependent and/or spouse is eligible for medical coverage through his/her employer.

If your spouse is eligible for employer group health insurance you must meet with EMS to determine if you are subject to the \$200 Working Spouse Surcharge.

Dependent's and/or Spouse's Name _____

Dependent's and/or Spouse's Employer _____

You may be subject to the Working Spouse Surcharge. The \$200 per benefit pay Spouse Surcharge will automatically be applied until this form is completed and returned to EMS. You are obligated to complete and file a new form if there is a change to your spouse's or dependent's insurance eligibility status. If you fail to properly complete this form, Xenia may recover the full amount of insurance premiums paid on behalf of your dependent, and/or hold you responsible for the cost of any and all claims associated with your dependent. If it is determined that you provided false information, you may be subject to disciplinary action up to and including termination from employment.

Employee Signature

Date

RETURN FORM TO EMS:

Attention Tracy: either via fax 513.561.0777 or tracy@enrollmentmanagementservices.com.