Notice to: All Stow Employees with Family Coverage under the Stow Group Health Plan

The following Group Health Benefit Plan provision has been adopted by all City Unions and has been approved by Stow City Council for the City's non-Union employees:

Stow employees hired before January 1, 2014, will be subject to a monthly spousal surcharge in the amount of 50.00 per month for a working spouse of any employee covered under the Stow Health Care Plan when such spouse has health care coverage available at the spouse's place of employment or through retirement, regardless of cost, but chooses Stow's health care coverage as primary. Stow employees hired *after* January 1, 2014, shall be subject to a $100.00 monthly spousal surcharge. Such spousal surcharge shall be paid by the employee and is in addition to any other premium or other costs or charges under the Stow Plan for the employee or spouse.

If your spouse is presently covered under Stow's Group Health Benefit Plan through **family coverage**, it is mandatory that you, the employee, complete the following verification:

Employee Verification of Spousal Coverage

(Required to be completed by all employees with Family Health Care Coverage through Stow)

Employee Name_____ **Spouse's Name**_____
(Please Print) **(Please Print)**

Verification: I hereby certify that my spouse (check only one) **is _____or is not _____** eligible for primary health care coverage through their employer or through retirement.

Verification: My spouse **will be primary** to Stow's health plan – **YES**_____ **NO**_____

If your spouse is covered under the City's Health Plan and is eligible for primary coverage at their place of work or through retirement, you will be charged $50/month or $100/month through payroll deduction for the spouse's coverage with the City of Stow, unless you decline to continue Stow coverage for your spouse.

I certify the information I have entered on this form to be accurate. I agree that it is my responsibility to notify the City of Stow within thirty (30) calendar days of any event that may change the status of the above-named spouse as it relates to the City's Health Plan.

I understand that, in addition to potential discipline, if applicable per appropriate appointing authorities, any eligibility misrepresentation or incorrect information I have provided herein may impact my spouse's coverage and may create liability for repayment of any benefits or claims paid on behalf of my spouse through the Stow Group Health Benefit Plan.

_____ _____

Employee Signature **Date**