



PLEASE PRINT ALL INFORMATION REQUESTED

YOUR FULL NAME - Last, First, Middle Initial
YOUR HOME PHONE - Include area code
YOUR SOCIAL SECURITY NUMBER
Your Marital Status
Are you and your spouse both covered by the State of Delaware Group Health Insurance Program?
SPOUSE'S FULL NAME - Last, First, Middle Initial
SPOUSE'S SOCIAL SECURITY NUMBER
SPOUSE'S BIRTH DATE

SPOUSE INFORMATION

My spouse is: Not Employed, Employed Full-time, Employed Part-time, Self-employed, Retired
NAME AND ADDRESS OF SPOUSE'S EMPLOYER
SPOUSE'S EMPLOYER PHONE NUMBER
Does your spouse's employer offer medical insurance to employees?
Is your spouse enrolled in medical insurance through his or her employer?
If yes, what is the insurance carrier's name?
Effective Date:
What is your spouse's plan policy number?
What percentage of the premium is paid by your spouse?
Annual plan renewal date for your spouse's employer:
Month: Day:
Does your spouse have a prescription drug program?
Your additional comments:
Name of Plan:
Effective Date: Policy No.:
If you are completing this form due to your spouse's loss of coverage please indicate the termination date of that coverage. Date:

AUTHORIZATION

I understand that the following policy applies to spouses who regularly work full-time and are eligible for medical coverage through their own employers:
- This information will be shared with the State of Delaware's plan administrator(s).
- If spouses take advantage of their own employer's medical coverage, their plans pay their benefits first. Then the State of Delaware will pay additional covered expenses, if any, up to the maximum allowed under our employee's family benefit plan, not exceeding a limit of 100% coverage from both plans combined.
- If spouses do not take advantage of their own employer's medical coverage, the State will pay 20% of covered services provided by the employer's family State of Delaware benefit plan.
The policy does not apply to:
- spouses not working full time, or
- spouses whose employers do not offer medical coverage, or
- spouses whose employers require a combination of more than 50% of the premium for the lowest benefit plan available, and
- eligible dependent children.
If any of this information changes, I must complete a new form within 30 days.

Notice to all parties completing this form: To insure benefits are coordinated properly between employers, the State of Delaware will verify the accuracy of information by conducting audits, contacting you, and contacting your spouse's employer. It is fraudulent to fill out this form with any information which is false or to omit important facts. Providing false information may result in disciplinary action.

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT
Employee's Signature
Date: / /

*Flexible benefits and credits apply towards employer's contribution.