Stoughton Health
2023 Adult Surcharge Questionnaire

Employee's Name _____
(Please print)

Adult's (Spouse/Domestic Partner) Name _____
(Please print)

If your adult dependent (Spouse or Domestic Partner) will be eligible for medical coverage under his or her employer in **2023** there will be $50 per pay period surcharge added to your paycheck if you choose to continue covering that adult under the Stoughton Health medical plan.

Option 1 - Surcharge

- ☐ I understand my spouse is employed (including self-employed) and eligible for coverage under his/her employer's medical plan and I choose to continue coverage through Stoughton Health? The $50 surcharge will be reflected on my paychecks.

_____ _____
Employee's Signature Date

Option 2 – Surcharge Waiver
Please circle your answer to ALL the questions below to determine if the surcharge waiver will apply to you.

Is your adult dependent:

1.	**covered/eligible for Medicare/Medicaid?** If yes, sign the bottom and return this form by the due date. You will not pay the $50 surcharge.	Yes	No
2.	**unemployed or self-employed with no employer medical coverage available?** If yes, sign the bottom and return this form by the due date. You will not pay the $50 surcharge.	Yes	No
3.	**employed by Stoughton Health and eligible for Stoughton Health medical coverage (both employed at Stoughton Health)?** If yes, sign the bottom and return this form by the due date. You will not pay the $50 surcharge.	Yes	No
4.	**employed and NOT eligible for coverage under his/her employer's medical plan?** If yes, documentation MUST BE APPROVED to Human Resources, from your spouse/domestic partner's employer confirming THE DEPENDENT IS NOT ELIGIBLE FOR medical coverage. Your $50 surcharge will continue until the documentation is received.	Yes	No

KNOWINGLY SUBMITTING FALSE INFORMATION COULD RESULT IN DISCIPLINARY ACTION UP TO AND INCLUDING TERMINATION OF EMPLOYMENT. DEPENDENT ELIGIBILITY WILL BE FREQUENTLY AUDITED.

I certify all information on this Affidavit is true, correct and current as of the date signed. Failure to return this Affidavit means you understand the $50 surcharge will be deducted from your paycheck and if the Affidavit is returned at a later time indicating your spouse or domestic partner does not have coverage through his/her employer, you will NOT be refunded any previous amount paid.

_____ _____
Employee's Signature Date

Return **annually and within 2 weeks of your hire or status change date** to Stoughton Health, Human Resources, **Fax (608)873-2355**