HACC, Central Pennsylvania's Community College
Certification and Election for Medical Coverage
For Spouse/Domestic Partner

NAME (printed): _____ HACC ID: _____

This form must be completed to cover a spouse or domestic partner on HACC's medical insurance.

Question	YES	NO	Action
1. Is your spouse/domestic partner (DP) employed?			If yes, skip to #3. If no, continue to #2.
2. Is your spouse/DP retired or disabled and does not file taxes?			If yes, skip to #8 and submit your 1040 tax form. If no, continue to #3.
3. Is your spouse/DP employed **full-time** by HACC?			If yes, provide spouse name here: _____ and skip to #8. This is the only form you need to submit. If no, continue to #4.
4. Is your spouse/DP self-employed?			If yes, continue to #5. If no, skip to #6.
5. Does your spouse's/DP's self-owned business offer health insurance to employees?			If yes, skip to #7. This is the only form you need to submit. If no, continue to #6.
6. Is your spouse/DP eligible for medical insurance at any place of employment?			If yes, continue to #7. This is the only form you need to submit. If no, continue to #8 below and submit the following: • Verification of Eligibility Form (page 3 below) if spouse/DP is employed at an organization other than self-owned business. • If married filing jointly: Submit your 1040 tax form showing you claimed your spouse. • If filed separately: Submit your spouse's/DP's 1040 tax form.

7. I (print your name)_____understand that by answering 'YES' to #5 or #6 above, I must pay an additional amount of $496.00 per month, in addition to the normal applicable premium share for the plan, to enroll my spouse in the HACC healthcare plan. Proceed to #8 below.

8. Sign and date below. Upload this completed form and all supporting documents to your employee file in the Streamlink enefits nrollment System.

- Click on the "**My Profile**" tab on your home page and then click on the "**Employee File**" link on the left side of the screen.
- Click on "**View and Upload Documents**" beside your name. You will see a screen used to upload and name your document.
- Enter a **title** for your document (ex. spousal form, marriage certificate, etc.) and a description (optional).
- Use the drop down box under "**Document Type**" to choose what type of document you are uploading.
- Click "**Choose File**" to find the file you would like to upload. Once completed, click "**Save**".
- The upload is successful if you see the green message box that states "**Employee File information was saved successfully**".

Contact **AskHR@hacc.edu** for assistance.

- Originals are not required.
- The $496.00 is applied automatically during open enrollment and will not be removed until all required documentation is received in the Office of Human Resources. Charges will not be refunded if documentation is received late.
- Charges will be removed no later than the first week of December**.** Due to the high volume of questions and transactions during and after open enrollment, please hold your inquiries about receipt of forms until the first week of December.

Signature of Employee (Required):_____Date: _____

By my signature on this form, I certify to HACC that all information and documentation provided is true, correct and current as of the date signed. I understand that is my responsibility to update my spouse/domestic partner eligibility for medical insurance with the Office of Human Resources should his/her eligibility change. Such notification must be submitted within 30 days from the date of the change. I further understand that if I knowingly submit false information, I may be subject to disciplinary action, up to and including termination and repayment of premiums. Furthermore, I authorize HACC to verify all documents provided and may contact the appropriate institution or organization to verify the facts stated herein.

HACC, Central Pennsylvania's Community College
Verification of Eligibility Form for Medical Coverage

Bottom section to be completed by spouse's/domestic partner's employer

HACC Employee Name: _____

Spouse/Domestic Partner Name: _____

To be completed by spouse's/domestic partner's employer:

Name of Organization: _____

1. Is the Spouse/Domestic Partner (named above) currently eligible for medical insurance coverage under your employer plan?

   YES_____NO _____

   If Yes, sign, date, and return the form to the address noted below. If No, continue to #2.

2. Why is the Spouse/Domestic Partner not eligible for your medical insurance? Please provide details, then sign, date, and return this form to the address on the bottom of this form.

   _____

   _____

I certify that the above information is accurate to the best of my knowledge as of the date signed.

Employer Representative Name (Printed): _____

Title: _____ Phone Number: _____

Employer Representative Signature: _____ Date: _____

By my signature on this form, I certify to HACC that all information and documentation provided is true, correct and current as of the date signed.

Sign, date, and return this form to:

HACC – Central Pennsylvania's Community College
ATTN: Benefits Coordinator
Fax: 717-901-4531
Email: Askhr@hacc.edu