PENNSYLVANIA EMPLOYEES BENEFIT TRUST FUND
DECLARATION OF SPOUSE/DOMESTIC PARTNER HEALTH COVERAGE
For Employees Hired on or After 8/1/2003

If your spouse/domestic partner is eligible for health benefits through his/her employer (or former employer), he or she must enroll in their employer's benefits. This requirement applies regardless of the cost of such coverage to your spouse/domestic partner. Your spouse/domestic partner can be enrolled in the PEBTF for secondary coverage only. Any claims must be submitted to your spouse/domestic partner's employer-sponsored health plan before they can be submitted for consideration of payment through the PEBTF health plans. The following information is required to confirm your spouse/domestic partner's eligibility and enrollment in their employer's health plan.

Employee and Spouse/Domestic Partner Information

Employee Name:_____ Employee Number:_____ Employee Date of Birth:_____

Spouse/Domestic Partner Name:

1. My spouse/domestic partner is currently (Select One):
   - ☐ Employed, either Full-Time or Part-Time, or Retired. Proceed to Question #2.
   - ☐ Not Employed or Self-Employed (no further action required). Sign, date and submit form. Proceed to #5.

2. Is your spouse/domestic partner a commonwealth employee or a retiree eligible for PEBTF or majority-state paid Retired Employees Health Program (REHP) coverage?
   - ☐ If yes, sign, date and submit form. Proceed to #5.
   - ☐ If no, proceed to Question #3.

3. Is your spouse/domestic partner eligible for health coverage through his/her employer or former employer?
   - ☐ If yes, proceed to Question #4.
   - ☐ If no, your spouse/domestic partner's employer must complete an Employer Benefit Verification Form (PEBTF- 36). Proceed to #5.

4. Is your spouse/domestic partner enrolled in his/her employer's health insurance or enrolled in a retiree health insurance plan?
   - ☐ If yes, sign, date and submit the form and provide copies of your spouse's/domestic partner's medical insurance card. Proceed to #5.
   - ☐ If no, sign, date and submit form. *Your spouse/domestic partner is not eligible for PEBTF coverage until he/she enrolls in his/her employer's health insurance.* Proceed to #5.

Please note: If your spouse/domestic partner is enrolled in a Health Savings Account and you enroll them in the PEBTF plan as secondary coverage, your spouse/domestic partner may incur financial penalties. Please verify with your spouse/domestic partner's plan that your spouse/domestic partner will not be subject to financial penalties before enrolling him/her in the PEBTF.

5. Signature: I declare that the foregoing information is true and correct to the best of my knowledge, information and belief. I understand that the PEBTF reserves the right to suspend or terminate my PEBTF group health plan coverage if it concludes I have provided false or misleading information in this Declaration. I understand that if my spouse/domestic partner is eligible to enroll under his/her employer's group health plan and does not, he/she is not eligible to be covered as a dependent in the PEBTF Plan. For medical expenses incurred by my spouse/domestic partner, the PEBTF will pay only secondary benefits and will consider claims for payment only after they have been submitted to my spouse's/domestic partner's employer's plan. If my spouse/domestic partner becomes employed or changes employment or his/her eligibility for health coverage changes, I agree to notify the HR Service Center (or my local HR Office for agencies not supported by the HR Service Center) and complete an updated Declaration of Spouse/Domestic Partner Health Coverage (PEBTF-11). I understand that the PEBTF may cancel my benefits (and my family's benefits) and I may be held responsible for costs in the event that it has been determined that the information provided was false or that my spouse/domestic partner was not eligible for benefits.

_____ _____
Employee Signature Date