Baltimore-Washington Conference
The United Methodist Church

BWC HEALTHFLEX PROGRAM
SPOUSAL SURCHARGE FORM

Most employment-based health insurance is subsidized by the employer. Therefore, HealthFlex participants whose spouses have access to health insurance coverage through their own employment, but who choose to decline that coverage and be covered under Baltimore-Washington Conference's group health plan (HealthFlex), will be subject to pay the extra monthly cost to the Conference or a premium surcharge of **$300 per month, whichever is less,** to compensate for the employer subsidy involved. To determine if the surcharge is applicable, clergy and lay employees with spouses who are planning to be covered by HealthFlex MUST complete the information below, at the time of enrollment and during open enrollment annually, and return this form to the BWC Human Resources and Benefits Office. If the surcharge is applicable, the Church will be billed and we will inform the Church Treasurer and SPRC so that this charge will be deducted from the participant's compensation on a pre-tax basis.

Please check the box that applies.

______My spouse is not employed. ***(Surcharge will not apply)***

______My spouse is employed at BWC or the Local Church. ***(Surcharge will not apply)***

______My spouse is self-employed and does not have access to health insurance coverage through his/her company. Written confirmation from spouse's business letterhead will be forwarded to the HR & Benefits office, within 30 days, indicating health insurance benefits are not available.
(Surcharge will not apply)

______My spouse is employed but does not have access to health insurance coverage through his/her employment. Attached is written confirmation from my spouse's employer that health insurance benefits are not available or that my spouse does not meet the health plan's eligibility requirements.
(Surcharge will not apply)

______My spouse is employed and has access to other health insurance coverage through his/her employment which we have declined and chose to continue my spouse's coverage through HealthFlex.
(Surcharge WILL apply)

Your signature below is an acknowledgement that you have accurately described your spouse's situation with regard to other health plan coverage. If your spouses' coverage situation changes during the year, it is your responsibility to notify the HR & Benefits office within 30 days of the event.

____ ____________________
Participant Signature Date

Participant's Name: ____
Please Print

Spouse's Name: ____
Please Print