The United Family | United supermarkets | Amigos | Albertsons Market | Market Street | United Express | RC Taylor Distributing | Prater's | LIANO

Working Spouse Surcharge Declaration

Once Completed Fax to: (806) 791-6341

Effective January 1, 2015, this form is required to be completed in full when a Team Member is enrolling a spouse (or seeking to continue enrollment of a spouse) in one of the medical plans. If a spouse is enrolled in dental or vision only, this form is not required. ***Verified spouses will be added to coverage with the Spousal Surcharge applied, if no form is received. This form must be renewed each Annual Enrollment Period.***

TEAM MEMBER INFORMATION

Team Member Name:		TM#:
Spouse Name:	Sp Birthdate	Spouse SSN:

1. Is your spouse employed? □ Yes □ No
   - If you checked **No**, please sign and date this form and return to the Benefits Department. The working spouse surcharge does not apply.
   - If you checked **Yes**, please provide the name of your spouse's employer and answer question #2.

   Name of spouse's employer _____
   (If your spouse is self-employed or employed by The United Family, please sign and date this form and return to the Benefits Department. The working spouse surcharge does not apply.)

2. Does your spouse's employer offer medical coverage for which he/she is eligible? □ Yes □ No
   - If you checked **No**, please sign and date this form and return to the Benefits Department. The working spouse surcharge does not apply.
   - If you checked **Yes**, please answer question #3.

3. Is your spouse enrolled in their employer offered medical plan? □ Yes □ No
   - If you checked **No**, please answer question #4.
   - If you checked **Yes**, please sign and date this form and return to the Benefits Department. The working spouse surcharge does not apply.

4. Do all of the medical plans offered by your spouse's employer qualify for any of the following:
   - An annual in-network out-of-pocket maximum that is more than $6,600 for employee only coverage. **Proof of coverage levels is required.** □ Yes □ No
   - An annual in-network maximum that is more than $13,200 for all other coverage levels. **Proof of coverage levels is required.** □ Yes □ No
   - If you checked **Yes** (on either option above) sign and date this form and return to the Benefits Department **along with your proof of coverage levels** to verify that the fee should not apply.
   - If you checked **No**, the working spouse surcharge applies. Please sign and date this form and return to the Benefits Department. You are subject to the $30 per week surcharge and will see a deduction each paycheck.
   - If any of the plans offered by your spouse's employer fall below the $6,600 or $13,200, the spouse surcharge applies.

By signing below, I represent and warrant that all information provided is accurate, current and complete to the best of my knowledge. I understand that falsification of information regarding spouse's coverage will result in the additional premiums surcharge being assessed retro-actively back to the date of the spouse's enrollment in one of the medical plans offered at United Supermarkets, LLC. In addition, I understand that a deliberate misrepresentation of the facts on this affidavit may subject me (the Team Member) to disciplinary action, up to and including termination of employment.

Team Member Signature:	Date: