



Human Resources Department
Administration and Finance
University of Cincinnati
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A monthly spouse/domestic partner surcharge will be added to your monthly contribution for medical coverage if you elect to cover your spouse/domestic partner and your spouse/domestic partner is eligible for coverage through his/her employer but chooses not to enroll in employer-provided coverage. If your spouse/domestic partner loses or obtains medical coverage through his/her employer, you must notify Human Resources within 31 days of such change.

The monthly surcharge is: **AAUP/UNREPRESENTED/ONA/FOP = \$50; AFSCME/IUOE/SEIU= \$25**

You must complete this form if you have elected medical coverage for your spouse or domestic partner. Failure to return this form will result in the Surcharge being deducted from your pay.

Section A – Employee/Spouse/Domestic Partner Information – Please print.	
Print Name:	UC ID (M#):
Spouse or domestic partner's name:	Initial Surcharge Response (SEIU)
IF spouse/domestic partner is a UC employee, provide UC ID (M #):	
Spouse or domestic partner's employer name and phone no.	
Section B – Spousal/Domestic Partner Surcharge Information - Complete this section if you have elected medical coverage for your spouse or domestic partner. Check appropriate box and fill in requested information.	
<input type="checkbox"/>	My spouse or domestic partner is not covered on my University of Cincinnati sponsored medical plan.
<input type="checkbox"/>	My spouse or domestic partner does not work, is self employed, or is also a University of Cincinnati employee.
<input type="checkbox"/>	My spouse or domestic partner is covered on my University of Cincinnati sponsored medical plan and does not have medical coverage available through his/her employer. Provide information requested in Section A.
<input type="checkbox"/>	My spouse or domestic partner is covered on my University of Cincinnati sponsored medical plan and is also enrolled in medical coverage through his employer. Provide information requested in Section A. Group Medical Plan Name _____ Certificate # _____ Effective Date: _____
<input type="checkbox"/>	My spouse or domestic partner is covered on my University of Cincinnati sponsored medical plan and has medical coverage available through his/her employer but has elected NOT to enroll in his/her employer's group medical plan. I understand the spouse surcharge will be deducted from my paycheck on a pre-tax basis.
Section D. Employee Verification and Signature	
My signature below indicates that the facts set forth on this form are true, correct and complete to the best of my knowledge. I understand: 1) the information I supplied may be audited by the University or its representatives, 2) if my spouse's/domestic partner's group medical insurance status changes, it is my responsibility to notify Human Resources in writing within 31 days of such change and failure to notify HR timely will prohibit you from making a change until the next annual enrollment period; 3) any false statements written on this form or on future forms as it relates to spousal/dependent health information may be grounds for disciplinary action up to and including termination of employment.	
Section E. Employee Signature and Date	