All employees who enroll for spousal medical coverage must complete this form

Working Spouse Affidavit
2020 Plan Year

DuPage County will impose a **$100 per month surcharge** on employees that elect to cover working spouses who are eligible for group medical coverage through his/her own employer (other than through DuPage County), or spouses that are retired and have access to a health plan through his/her previous employer (other than through DuPage County). If, at any point, your spouse ceases to be eligible for his/her employer's medical coverage, he/she may be enrolled under your DuPage County medical plan coverage. You will have 30 days from the loss of eligibility to enroll your spouse under our plan.

An open enrollment under another employer's benefit plan is considered a permitted mid-year change in status event under Section 125. If your spouse's open enrollment occurred earlier in the year and your spouse chose not to enroll in coverage for which he/she was eligible for, he/she should contact his/her employer and request to enroll effective January 1, 2020.

This surcharge does not apply toward dependent children. You are still able to enroll your dependent children in the County medical plan regardless of your spouse's status under this restriction. Please contact the Benefits Division if you have any questions.

Employee Name (Last, First, MI):	**Employee ID #:**	**Dept:**

Please read all options and check one:

- ❑ My spouse is **unemployed** and will be covered under the DuPage County medical plan. ***The $100 per month surcharge WILL NOT apply.***

- ❑ My spouse is ❑ **employed** / ❑ **retired, but not eligible** for group medical coverage through his/her own employer and will be covered under the DuPage County medical plan. You will need to provide a letter on company letterhead, from his/her employer, for verification (unless retired). This letter must be received prior to the due date noted above. ***The $100 per month surcharge WILL NOT apply.***

- ❑ My spouse is **employed or retired and eligible** for group medical coverage through his/her own employer. ***The $100 per month surcharge WILL apply.***

- ❑ My spouse is a DuPage County employee. ***The $100 per month surcharge WILL NOT apply.***

I do hereby attest that the above information is true and correct to the best of my knowledge. I understand DuPage County reserves the right to request supporting documentation and any proof as it, in its sole discretion, deems necessary in order to verify the representations I have made in this Affidavit. I also understand that if my spouse's group medical insurance status changes, it is my responsibility to notify Human Resources within 30 days of such change. **Retroactive payroll contribution adjustments and/or disciplinary action up to and including termination of employment may apply if my spouse is covered under the DuPage County medical plan and it is later determined that my spouse was eligible for other group medical coverage through his/her employer.**

Signature____**Date** _____________________

TURN PAGE OVER

All employees enrolling in medical coverage must complete this form

Tobacco Status Affidavit
2020 Plan Year

If you smoke or use tobacco products (including, but not limited to, cigarettes, snuff, chewing tobacco, pipes, hookah, or any other lighted smoking equipment) on a regular basis (within the last 6 months), a **$75 per month surcharge** will apply to your medical plan contribution.

If you are a tobacco user and complete the "**Well On Target" Self-Directed Interactive Course titled "Quitting Tobacco Use", 6-week online smoking cessation program** available through Blue Cross Blue Shield of Illinois (*See www.bcbsil.com to login to your personal portal*) by September 1, 2020, we will refund the tobacco user surcharge, and discontinue any further tobacco user surcharge for the remainder of the plan year.

This surcharge does not apply toward your spouse or dependent children, unless an employee of the County.

Please contact the Benefits Division if you have any questions.

Employee Name (Last, First, MI):	Employee ID #	Dept:

Please check one option below:

- ❑ I smoke or use tobacco products on a regular basis. ***The $75 per month surcharge WILL apply.***
- ❑ I do not smoke or use tobacco on a regular basis. ***The $75 per month surcharge WILL NOT apply.***

I agree to notify the Benefits Division promptly at any time that I begin smoking or using tobacco products and understand that such use may cause the Tobacco User Surcharge to apply.

I further understand that knowingly falsifying this form or making any false statement or representation in connection with this form may result in loss of health coverage and/or disciplinary action up to and including termination of employment.

Signature____Date __________________

TURN PAGE OVER