

**PENNSYLVANIA EMPLOYEES BENEFIT TRUST FUND**  
**DECLARATION OF SPOUSE HEALTH COVERAGE**  
**Active Employee on July 31, 2003**

The Trustees of the PEBTF require information regarding group health coverage available to the spouse of Commonwealth employees. Spouse enrollment in the PEBTF requires primary coverage under the spouse's employer's group health plan, if there is no cost to my spouse to enroll or if there is no financial incentive to waive coverage. This information will only be used to confirm spouse health coverage and for coordination of benefits purposes.

Employee \_\_\_\_\_ Social Security Number \_\_\_\_\_

Spouse name \_\_\_\_\_ Spouse Social Security Number \_\_\_\_\_

\_\_\_\_\_ My spouse is not currently employed outside the house, or is self-employed

\_\_\_\_\_ My spouse is employed/retired by: Name \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

**Spouse Employer's Health Coverage**

\_\_\_\_\_ My spouse is currently covered by his/her employer's group health insurance (check all that apply):

\_\_\_\_\_ Medical

\_\_\_\_\_ Dental

\_\_\_\_\_ Vision

\_\_\_\_\_ Prescription Drug

\_\_\_\_\_ My spouse's employer does not offer group health coverage for which he/she is eligible.

\_\_\_\_\_ My spouse is eligible for group health coverage through his/her employer, but has declined such coverage.

\_\_\_\_\_ My spouse's employer requires an employee contribution to participate

\_\_\_\_\_ My spouse's employer offers a financial incentive to decline coverage.

\_\_\_\_\_ Other (explain) \_\_\_\_\_

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 coverage if it concludes I have provided false or misleading information in this Declaration. I understand that if my spouse's employer offers group health coverage at no cost to my spouse and with no financial incentive to decline coverage, my spouse must enroll in his/her employer's plan. I understand that if my spouse does not so enroll, he/she is ineligible to be covered as a dependent in the PEBTF. Finally, I understand that my spouse's group health plan from his/her employer is his/her primary insurance plan, and PEBTF coverage is secondary. If my spouse should change employment or his/her eligibility for health coverage should change, I am required to notify my local Human Resources Office and complete an updated Declaration of Spouse Health Coverage.

\_\_\_\_\_  
Signature of PEBTF Member

\_\_\_\_\_  
Date