PENNSYLVANIA EMPLOYEES BENEFIT TRUST FUND
DECLARATION OF SPOUSE HEALTH COVERAGE
For Employees Hired on or After 8/1/2003

If your spouse is eligible for health benefits through their employer (or former employer), they must enroll in their employer's benefits. This requirement applies regardless of the cost of such coverage to your spouse. Your spouse can be enrolled in the PEBTF for secondary coverage only. Any claims must be submitted to your spouse's employer-sponsored health plan before they can be submitted for consideration of payment through the PEBTF health plans. The following information is required to confirm your spouse's eligibility and enrollment in their employer's health plan.

Employee and Spouse Information

Employee Name:_________________________ Employee Number:________________ Employee Date of Birth:________

Spouse Name:

1. My spouse is currently (Select One):
   - ☐ Employed Full-Time (Proceed to Question #2)
   - ☐ Employed Part-Time (Proceed to Question #2)
   - ☐ Retired (Proceed to Question #2)
   - ☐ Not Employed (No further action required. Proceed to Question #5 – Sign, date and submit form)
   - ☐ Self-Employed (No further action required. Proceed to Question #5 – Sign, date and submit form)

2. Is your spouse a commonwealth employee or a retiree eligible for PEBTF or majority-state paid Retired Employees Health Program (REHP) coverage?
   - ☐ If yes, sign, date and submit form. Proceed to #5.
   - ☐ If no, proceed to Question #3.

3. Is your spouse eligible for health coverage through their employer or former employer?
   - ☐ If yes, proceed to Question #4.
   - ☐ If no, your spouse's employer must complete an Employer Benefit Verification Form (PEBTF-36). Proceed to #5.

4. Is your spouse enrolled in their employer's health insurance or enrolled in a retiree health insurance plan?
   - ☐ If yes, sign, date and submit the form and provide copies of your spouse's medical insurance card. Proceed to #5.
   - ☐ If no, sign, date and submit form. *Your spouse is not eligible for PEBTF coverage until they enroll in their employer's health insurance.* Proceed to #5.

Please note: If your spouse is enrolled in a Health Savings Account and you enroll them in the PEBTF plan as secondary coverage, your spouse may incur financial penalties. Please verify with your spouse's plan that your spouse will not be subject to financial penalties before enrolling them in the PEBTF.

5. 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 plan coverage if it concludes I have provided false or misleading information in this Declaration. I understand that if my spouse is eligible to enroll under their employer's group health plan and does not, they are not eligible to be covered as a dependent in the PEBTF Plan. For medical expenses incurred by my spouse, the PEBTF will pay only secondary benefits and will consider claims for payment only after they have been submitted to my spouse's employer's plan. If my spouse becomes employed or changes employment or their eligibility for health coverage changes, I agree to notify the HR Service Center (or my local HR Office for agencies not supported by the HR Service Center) and complete an updated Declaration of Spouse Health Coverage (PEBTF-11_Active). I understand that the PEBTF may cancel my benefits (and my family's benefits) and I may be held responsible for costs in the event that it has been determined that the information provided was false or that my spouse was not eligible for benefits.

______________________________ ______________________________
Employee Signature Date