Pennsylvania's
STATE SYSTEM
of Higher Education

Spouse – Employer Information Form

State System Employee's Name: _____

Employee's Name (State System Employee's Spouse): _____

If a State System employee wishes to enroll their spouse in the State System health plan, and that spouse is eligible for coverage under their own employer's plan, the spouse shall be required to enroll in their own employer's plan as a condition of eligibility for secondary coverage under the State System health plan.

Please complete the top section then provide to your spouse's employer. The completed form should be provided to your university's benefits office.

Spouse Employment Information (To be completed by the spouse's employer)

Employer: _____

Address: _____

Does your organization provide single healthcare coverage at no cost to an employee (i.e. fully employer paid)?

Yes ☐ No ☐

Is the employee named above employed in a health benefits eligible position with your organization?

Yes ☐ No ☐

Is the employee named above enrolled in your organization's health plan?

Yes ☐ No ☐

If the employee is not enrolled in your organization's health plan, would you permit the employee to enroll in your health plan coverage now under a HIPPA special enrollment event since the State System requires spouses that are offered health care coverage by their employer to enroll in that coverage in order to have State System health plan coverage as secondary insurance?

Yes ☐ No ☐

If the question above is "No", please indicate the date of your annual (open) enrollment: _____

Employer Representative Information

Name: _____

Title: _____

Telephone: _____ Email: _____ Date: _____

Date revised 3/10/21