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SPOUSAL COVERAGE PROVISION - Effective January 1, 2022

(You and your spouse must complete sign this form)

A "Spousal Coverage" provision has been initiated and is designed to require other third party employers to pay their share of health care costs.

If you are married and your spouse is employed and eligible for subsidized healthcare coverage from his/her employer, then he/she is no longer eligible for the KIMBLE Group health plan. This provision also applies to an employee's spouse that has retired and is eligible for health care coverage through his/her former employer.

If your spouse is self-employed and does not have access to group health coverage, or if your spouse is not working or is not eligible for subsidized coverage through their employer, then he or she is eligible to participate in the KIMBLE Group health plan, provided you are eligible to participate. If your spouse must complete a waiting period to enroll for coverage under his/her employer's health plan, during that waiting period he/she will be eligible to participate in KIMBLE Group's health plan provided you are eligible to participate.

If your spouse has a change in his or her employment status and becomes eligible for subsidized group health coverage, he/she must enroll in that coverage as soon as he/she is eligible. You are responsible for notifying Human Resources within 30 days when this situation occurs.

You will need to indicate whether your spouse is eligible for other employer-sponsored health coverage. You will be asked to certify that your spouse has health coverage and to provide information about that coverage, or to certify that his/her employer does not offer health coverage. **If you do not respond it will be assumed that your spouse has alternative health coverage available.** If you provide false information, or fail to notify the Human Resources Department of any required information, you will become personally liable for any benefits paid by Medical Mutual under the KIMBLE Group on behalf of your spouse that would not have been paid had KIMBLE Group had accurate information. In addition, your insurance may be terminated and/or your employment may be terminated.

Every employee (whether married or single) is required to complete the Spousal Coverage Questionnaire included in this packet and return it to the Human Resources Department. If the Questionnaire is not returned, your spouse's claims will not be paid until the information is received.

KIMBLE Group
Health Plan
Spousal Coverage Questionnaire Form

Failure to complete this form will result in a denial of payment of your spouse 's healthcare claims and no reimbursement of payroll withholding amounts. **You and Your Spouse must sign this form.**

SECTION A - Marital Determination

KIMBLE Group Employee Name_____

Are you married or legally separated (but not yet divorced)? ☐ Yes ☐ No

If NO: Complete Section D of the form and turn it in to HR.

If YES:

Complete Section B if your spouse **does not** have other coverage available.

OR

Complete Section C if your spouse **does have** other coverage available or if your spouse is an employee of KIMBLE Group.

SECTION B - No Other Coverage Available

Spouse 's Name _____

This is to certify that the Employee's spouse does not have the option of other healthcare coverage. Please check ONE of the situations that applies to your spouse.

1)___ My spouse is not employed and does not otherwise have access to a group health plan.

2)___ My spouse is employed/retired and does not have access to a group health plan.

GO TO SECTION D NEXT.

SECTION C - If Your Spouse Has Coverage Available

Spouse 's Name _____

Check only ONE of the following:

□ My spouse is covered by **KIMBLE** Group health benefits. Please GO TO Section D next.

□ This is to certify that my spouse is/will be enrolled in healthcare benefits through his/her employer. Please provide the following information if you checked this box.

Employer Name _____

GO TO SECTION D NEXT.

SECTION D - Employee Certification/Spousal Release

I understand it is my responsibility to notify KIMBLE Group Human Resources within 30 days in the event that any changes occur in my marital status or the employment/eligibility status of the above named spouse.

I understand that I am personally liable for any benefits paid should any of the above information be inaccurate.

I understand that any willful misrepresentation of facts on this enrollment form will be grounds for discharge from employment and termination of benefits as well as insurance fraud.

I hereby certify that the foregoing information is true and correct.

Employee Signature_ Date_ _ _ _ _ _ _ _ _ _ _ _

Employee's Spouse Signature (if married)_ Date_ _ _ _ _ _ _ _ _ _ _ _