SAN ANTONIO WATER SYSTEM
2024 Spouse Premium Surcharge Waiver Form

The 2024 Spouse Premium Surcharge is a $150 monthly surcharge ($75.00 per pay period) that is required above and beyond the regular employee medical contribution (premium) rate for SAWS active and pre-65 retiree medical plans. It is intended to encourage those spouses who have access to alternative medical coverage to move from the SAWS sponsored medical plan to his or her own employer's plan. If your spouse does not have access to other available coverage through his/her own employer or former employer, you may be eligible to waive this surcharge (see criteria below).

To request a waiver of the surcharge for the 2024 Benefit Plan Year, please complete and submit this waiver form along with required documentation (as listed below) *within 31 days of your hire date or qualifying event date.*

SECTION 1: AFFIDAVIT TO WAIVE THE 2024 SPOUSE PREMIUM SURCHARGE

I am hereby requesting to have the Spouse Premium Surcharge **WAIVED** because I meet one of the following criteria. I understand that I must provide documentation as indicated on my selection below. If my spouse's employment status changes, I understand that this form must be updated and re-submitted.

Please select ONE of the following criteria below that applies to your spouse (check one box only):

☐ My spouse is not presently employed and does not have access to health coverage through his/her own employer or former employer. **Submit this Waiver Form only, unless this event occurs after the Open Enrollment period, in which case provide a letter from the former employer.**

☐ My spouse is self-employed without access to other medical coverage. **Submit this Waiver Form only.**

☐ My spouse is covered by Medicare Part A, Tricare or CHAMPVA insurance and enrolled in a SAWS medical plan. **Submit this Waiver Form AND a copy of spouse's Medicare, Tricare or CHAMPVA ID.**

☐ My spouse is employed, but his or her employer does not offer medical coverage or is not eligible for medical coverage by his or her employer. **Submit this Waiver Form AND complete Spouse Employer Certification on reverse side of this form.**

NOTE: THERE IS NO RETROACTIVE REIMBURSEMENT OF THE SURCHARGE.

EMPLOYEE CERTIFICATION

I certify that the information I am providing is true and accurate to the best of my knowledge. I understand that intentional misrepresentation of the facts above is considered insurance fraud and may result in recoupment of any and all benefits improperly paid on my behalf by SAWS self-funded medical plans AND may lead to disciplinary action, up to and including employment termination.

Printed Name of SAWS Employee/Retiree	Employee ID#
Signature of SAWS Employee/Retiree	Date
Printed Name of Spouse	
Signature of Spouse	Date

Deadline: 31 Days from Hire Date or Qualifying Event Date

Submit your form and documentation to the attention of SAWS HR Benefits Office:
SCAN AND EMAIL:
BenefitsInquiries@saws.org
For Questions: 210-233-2025

NOTE: This form must be updated and re-submittedif your spouse's status changes.

See reverse side for Section 2, Spouse Employer Certification

SAN ANTONIO WATER SYSTEM
2024 Spouse Benefits Eligibility Verification Form

SECTION 2: SPOUSE EMPLOYER

If your spouse is employed, but his or her employer does not offer medical coverage or he/she is not eligible for coverage, you may be eligible to waive this surcharge. This page must be completed by your spouse's employer if he/she is not eligible for the employer's coverage.

Instructions to employer: Please certify that the spouse named herein is employed by your company and indicate his or her medical benefits eligibility with your company. If this member will be eligible for medical benefits at a future date, please provide the date his or her coverage may begin. Please contact the Benefits Office at San Antonio Water System, with any questions, at 210-233-2025.

I hereby certify that _____ is employed by
Spouse of SAWS Employee

_____.
Company name

I further certify that:

☐ This employer does not provide medical coverage to employees.

☐ Employee will be eligible for medical coverage in the future. Date Eligible: _____
(It is the responsibility of the SAWS employee to follow up with their spouse's employer regarding any changes to the eligibility date, and provide an updated Surcharge Waiver Form.)

☐ The employee named above is not eligible for employer medical coverage.
Reason for no coverage: _____

_____
Name and Title of Benefits Analyst/HR Administrator (please print)

_____
Phone number and email address of Benefits Analyst/HR Administrator

_____
Benefits Analyst/HR Administrator Signature Date Signed

Deadline: 31 Days from Hire Date or Qualifying Event Date

Submit your form and documentation to the attention of SAWS HR Benefits Office:

MAIL: P.O. BOX 2449, San Antonio, TX 78298
SCAN AND EMAIL: BenefitsInquiries@saws.org
FAX: 210-233-5460
PHONE: 210-233-2025

NOTE: This form must be updated and re-submitted if your spouse's status changes.