MeridianBank

SPOUSE/DOMESTIC PARTNER WORKING AFFIDAVIT

Benefit Period: July 1, 2026 to June 30, 2027

Personal Information

Employee Name *(Please Print):*

Spouse/Domestic Partner's Name *(Please Print):*

If your Spouse/Domestic Partner is eligible for coverage through their employer and does not enroll in those benefits, but elects to enroll in the Meridian Bank medical/prescription drug (including Davis Vision) benefits plan, a surcharge of $46.15 will be added to your per-pay medical/prescription drug (including Davis Vision) contribution. **This form is due back to Human Resources by your initial enrollment date**. If the form is not received by then, **you will automatically be charged the $46.15 per-pay surcharge beginning with your first payroll deduction**. This surcharge will be applied each pay period until this form is received and reviewed by Human Resources.

Is your Spouse/Domestic Partner employed?

☐ **Yes - Complete the remainder of this form**

☐ **No - Sign and date the bottom of this form** *(Documentation may be requested - e.g., unemployment statement, SSI payments, state assistance, etc.)*

Is your Spouse/Domestic Partner offered health coverage through their employer?

☐ **Yes** ☐ **No**

Spouse/Domestic Partner Employer Information:

EMPLOYER NAME:

HR/BENEFITS CONTACT & PHONE NUMBER:

If your Spouse/Domestic Partner is NOT enrolled in their employer's medical/prescription plan, please choose from the following:

☐ **My Spouse/Domestic Partner will enroll during their employer's open enrollment period (provide date):** _____

Please Note: Once your Spouse/Domestic Partner enrolls in their employer's medical/prescription drug plan, the surcharge of $46.15 will no longer apply to your per-pay contributions. You must notify Human Resources to remove your Spouse/Domestic Partner from your medical/prescription drug coverage (including Davis Vision).

☐ **My Spouse/Domestic Partner will NOT enroll in their employer's plan and will remain on Meridian Bank's medical plan.**

By selecting this option, please note that you will be required to pay the $46.15 surcharge per pay period.

☐ **My Spouse/Domestic Partner is a newly hired employee and not eligible for coverage until (provide date):** _____

Please Note: The surcharge will not be applied until your Spouse/Domestic Partner's coverage with their employer begins. You are required to notify Human Resources as soon as your Spouse/Domestic Partner's coverage becomes effective.

☐ **My Spouse/Domestic Partner is employed part-time and does not qualify for benefits under their employer's plan.**

Please Note: The surcharge will not be applied until your Spouse/Domestic Partner's coverage with their employer begins. You are required to notify Human Resources as soon as your Spouse/Domestic Partner's coverage becomes effective.

☐ **My Spouse/Domestic Partner is self-employed and does not have medical/prescription drug coverage - proof may be requested.**

☐ **My Spouse/Domestic Partner is retired.**

ATTESTATION:

I certify that the answers I have provided on this form are true and accurate. I understand that a person may be committing insurance fraud if they submit a form containing false information or deceptive statements. I further understand that if it is discovered that I made false or deceptive statements on this form, I will be subject to disciplinary action up to and including termination of employment.

Employee's Signature Date

Spouse/Domestic Partner's Signature Date