The United Family | United | Amigos | Albertsons | Market Street | United Express | B.C. Taylor | Reed's | LIANO

Working Spouse Surcharge Declaration

Once Complete Fax to: 806-791-6341.

Effective January 1, 2015, this form is required to be completed in full when a Team Member is enrolling a spouse (or seeking to continue enrollment of a spouse) in one of the medical plans. ***No Spouse will be eligible or be enrolled in a Medical Plan until this form is completed and returned.***

TEAM MEMBER INFORMATION

Team Member Name:	TM#:
Spouse Name:	Spouse SSN:

1. Is your spouse employed? □ Yes □ No
   If you checked **No**, please sign and date this form and return to the Benefits Department. The working spouse surcharge does not apply.
   If you checked **Yes**, please provide the name of your spouse's employer and answer question #2.
   Name of spouse's employer _____
2. Will your spouse be enrolled in his/her employer medical plan? □ Yes □ No
   If you checked **Yes**, please sign and date this form and return to the Benefits Department. The working spouse surcharge does not apply.
   If you checked **No**, please answer question #3.
3. Does your spouse's employer offer medical coverage for which he/she is eligible? □ Yes □ No
   If you checked **No**, please sign and date this form and return to the Benefits Department. The working spouse surcharge does not apply.
   If you checked **Yes**, please answer question #4.
4. Does the medical coverage offered by your spouse's employer have an annual in-network out-of-pocket maximum that is more than $6,600 for employee only coverage or more than $13,200 for all other coverage levels? If you don't know, please have your spouse contact his/her benefits department for clarification.
   □ Yes □ No
   If you checked **Yes**, please provide the amount: _____. Then sign and date this form and return to the Benefits Department. The working spouse surcharge does not apply.
   If you checked **No**, the working spouse surcharge applies. Please sign and date this form and return to the Benefits Department. You are subject to the $30 per week surcharge and will see a deduction each paycheck.
5. □ Not applicable (i.e., electing Team Member Only or Team Member + Children coverage, response of "no" for all of the above questions regarding your spouse, or declining coverage)

By signing below, I represent and warrant that all information provided is accurate, current and complete to the best of my knowledge. I understand that falsification of information regarding spouse's coverage will result in the additional premiums surcharge being assessed retro-actively back to the date of the spouse's enrollment in one of the medical plans offered at Albertsons - United Division. In addition, I understand that a deliberate misrepresentation of the facts on this affidavit may subject me (the Team Member) to disciplinary action, up to and including termination of employment.

Team Member Signature:	Date: