

# Star Tribune

## Spousal/Domestic Partner Eligibility Certification

Instructions: Employees must complete and return or fax this form to the Star Tribune Benefits Department, 1st Floor, 425 Portland Avenue, Minneapolis, MN 55488, fax number 612-673-7584, by Nov. 23, 2011 in order to have spousal medical coverage in 2012.

Spousal/Same-Sex Domestic Partner Eligibility Policy: Employees are allowed to cover a lawful spouse or an eligible same-sex domestic partner under our health plans, unless the spouse or domestic partner is eligible for medical coverage under his/her own employer's plan. If eligible for medical coverage with his/her own employer, the spouse or same-sex domestic partner is not eligible for medical coverage with Star Tribune.

### SECTION I – EMPLOYEE INFORMATION (Please print)

Name: \_\_\_\_\_ Employee ID #: \_\_\_\_\_

### SECTION II – SPOUSAL/SAME-SEX DOMESTIC PARTNER ELIGIBILITY

Complete if you are covering your spouse/same-sex domestic partner under a Star Tribune-sponsored medical plan.

1. Name of spouse/domestic partner: \_\_\_\_\_
2. Is your spouse/domestic partner actively employed?  Yes  No
3. Name of spouse/domestic partner's employer: \_\_\_\_\_  
Employer's address: \_\_\_\_\_
4. Is your spouse/domestic partner eligible for medical coverage from his/her employer?  Yes  No

### SECTION IV – CERTIFICATION

I certify that the information provided above is correct as of the date below. I agree to notify Star Tribune within 31 days if there is any change in the information provided above. I understand that I will need to re-certify the information provided above at every annual enrollment. I understand that if I falsely certify the eligibility of the person listed above, if I otherwise misstate, misrepresent, or omit facts relevant to the eligibility of the person listed above, or if I fail to submit the documentation required as part of a dependent eligibility review, or if I fail to update based on a change in eligibility, this could lead to disciplinary action, up to and including termination of my employment. I further understand that I may become liable for all benefits paid from the Plan on behalf of the person listed above (or any other ineligible individual that I have covered) for the period of time during which the person is ineligible for medical benefits from the Plan, and expenses associated with repayment of these benefits (including attorneys' fees).

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date