641-623-5401 | 3006 Brownells Pkwy., Grinnell, IA 50112

Statement of Dependent's Eligibility for Benefits

*Please complete the following **ONLY** if you have elected spousal coverage under the 2nd Adventure Payroll Services **Medical** OR **Dental** Plan.*

Employee Name (First, M.I. Last) _____

Spouse's Name (First, M.I. Last) _____

Spouse Information - Please Check Appropriate Box:

- ☐ My spouse is unemployed
- ☐ My Spouse is self-employed
- ☐ My Spouse is employed by 2nd Adventure Payroll Services LLC
- ☐ My spouse is employed, but his/her employer does not provide medical and/or dental coverage*****
- ☐ My spouse is employed, but not eligible for his/her employer's medical and/or dental coverage*****

******SPOUSE EMPLOYER LETTER* MUST BE COMPLETED**

Spouse's Employer Information

Employer Name: _____

Address: _____

Contact Name: _____

Phone: _____

Plan Provision

If your spouse is employed and eligible for coverage under a group medical or dental plan offered by his/her employer, and that employer contributes to his/her medical insurance or dental premiums, they will not be eligible to come on 2nd Adventure Payroll Services medical or dental plan. Your spouse must enroll for employee coverage on his/her employer's plan.

Should the employment status of your spouse change, or should there be other status changes for you, your spouse or dependents that would affect eligibility, please contact Human Resources WITHIN 30 DAYS OF THE CHANGE.

I hereby certify that the above information is complete and accurate.

Employee Signature: _____ Date: _____