

**EUGENE SCHOOL DISTRICT 4J – HIRE A SPOUSE/DEPENDENT FORM**

This form is needed to confirm or waive eligible dependent coverage continuance after a 4J retiree terminates from the plan due to Medicare eligibility. Please complete this form and submit to 4J Human Resources 30 days prior to retiree coverage ending.

Retiree Name:	DOB:
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I elect to waive benefits for my eligible dependent(s) as of \_\_\_\_\_ (the date of my Medicare eligibility)

I elect to continue benefits for my eligible dependent(s) after I become Medicare eligible

I understand that any eligible dependents covered under my plan will be enrolled in health benefits only, on a self-pay basis (without any district contribution) until no longer eligible.

I understand that once my covered spouse/domestic partner becomes Medicare eligible, he/she will no longer be eligible to continue on this health plan.

I understand that once my covered child attains age 26, in most cases, he/she is no longer eligible to continue on this health plan.

I understand that I am solely responsible to notify Human Resources with a Midyear Change Form within 31 days of any Qualifying Status Change that will affect my elected benefits (ie: divorce, marriage, new or dissolved domestic partnership, etc.)

I understand that an updated ACH form in my dependent’s name is required to pay for all insurance premiums.

**Dependent(s) Information:**

**Dependent 1**

*(Administrative note only: Please add only this dependent to Lawson)*

Last Name:	First Name:	Middle Initial:	Relationship to Retiree:
Social Security Number:		Date of Birth:	
Gender:	Ethnicity:	Race:	
Street Address:			
City:	State:	Zip Code:	
Email address:		Phone Number:	

For more dependents, please use additional page

\_\_\_\_\_  
Signature of retiree

\_\_\_\_\_  
Date

**Additional Dependent Information:**

**Dependent 2**

Last Name:	First Name:	Middle Initial:	Relationship to Retiree:
Social Security Number:		Date of Birth:	
Gender:	Ethnicity:	Race:	
Street Address:			
City:	State:	Zip Code:	
Email address:		Phone Number:	

**Dependent 3**

Last Name:	First Name:	Middle Initial:	Relationship to Retiree:
Social Security Number:		Date of Birth:	
Gender:	Ethnicity:	Race:	
Street Address:			
City:	State:	Zip Code:	
Email address:		Phone Number:	

**Dependent 4**

Last Name:	First Name:	Middle Initial:	Relationship to Retiree:
Social Security Number:		Date of Birth:	
Gender:	Ethnicity:	Race:	
Street Address:			
City:	State:	Zip Code:	
Email address:		Phone Number:	