

## ESS – Personal Information – Family/Related Persons – Spouse/Domestic Partner Attestation

1. To complete the Spouse/Domestic Partner Health Care Enrollment Attestation, click on the Attestation button as shown to begin the process.

**Family Member / Related Person Information**

This page displays a listing of all family members and/or related persons stored on your personnel file in the PASSHE HCM system and can be used to validate whether the displayed information is correct or if updates to your personnel file are required.

Saved Family Members					Spouse/Domestic Partner Attestation
Relationship	No	Full Name	SSN		
Spouse				Update SSN	Attestation
Child	01			Update SSN	
Child	02			Update SSN	
Child	03			Update SSN	

To view the details of a person, select a row in the table above by clicking the button at the beginning of the row.  
If any of the dependent data displayed is incorrect (except for social security number), please contact your benefits coordinator.

2. The following pop-up window will be displayed. Click on the “Provide Spouse/Domestic Partner Health Care Enrollment Attestation” button.

**Employee Attestation**

**Spouse/Domestic Partner Health Care Enrollment Attestation**

If you wish to continue your spouse's/domestic partner's enrollment in the State System health care plan, you are required to complete the Spouse/Domestic Partner Health Care Enrollment Attestation.

**Failure to provide spouse/domestic partner health care enrollment attestation will impact your spouse's/domestic partner's enrollment in the State System health care plan.**

Your attestation was last updated effective: 7/1/2013

Provide Spouse/Domestic Partner Health Care Enrollment Attestation Cancel

- 3. The current spouse/domestic partner attestation on file for the employee record will be displayed.

**Employee Attestation**

### Employee Attestation

#### Spouse or Domestic Partner's Information

##### Spouse/Domestic Partner Employment

My Spouse/Domestic Partner is:

##### Employment Information

Spouse/ Domestic Partner's Employer:   
Employer Address:   
Employer City:   
Employer State:   
Employer Zip:  -   
Employer Phone:  -

##### Spouse/Domestic Partner's Health Care Coverage

Does your spouse's/domestic partner's employer offer health care coverage for which he/she is eligible?:   
Is your spouse/domestic partner enrolled in that plan?:   
Next Enrollment Date (if not enrolled):   
Insurance Provider:   
ID/Policy Number:   
Policy Effective Date:

[I certify my spouse/domestic partner health care enrollment attestation remains the same.](#)  
 [I need to update my spouse/domestic partner health care enrollment attestation.](#)  
 [Cancel](#)

4. If the attestation to be provided matches the current data in the system, choose the “I certify my spouse/domestic partner health care enrollment attestation remains the same” as shown here and skip to step 5 below.

Policy Effective Date: 1/1/2015

[I certify my spouse/domestic partner health care enrollment attestation remains the same.](#)

[I need to update my spouse/domestic partner health care enrollment attestation.](#)

[Cancel](#)

If the attestation to be provided does not match the current data in the system, skip to step 6 below.

5. The “Certification” information section will automatically appear to certify the information provided is true and correct. Click in the “I declare that I have read the above certification and that all provided information is correct” box to agree.

Next, click the “Save my attestation data” button.

Insurance Plan: The Mark

ID/Policy Number: 123456789

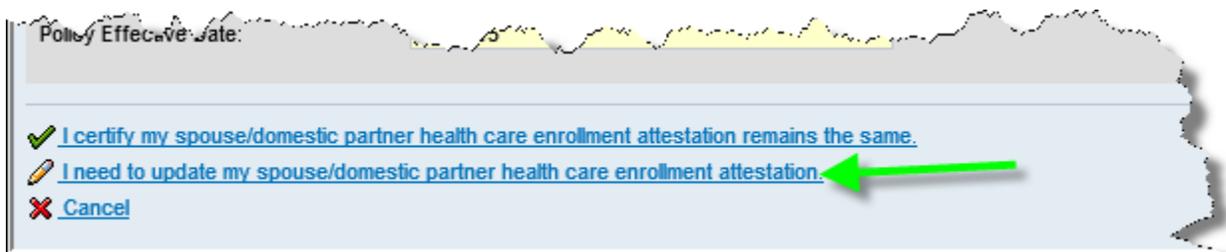
Policy Effective Date: 1/1/2015

**Certification**

I declare that all information above is true and correct to the best of my knowledge. If my spouse's/domestic partner's employer offers group health coverage, my spouse/domestic partner must enroll in his/her employer's plan regardless of any cost to my spouse/domestic partner. I understand that if my spouse/domestic partner does not enroll, he/she is ineligible to be covered as a dependent in the PASSHE plan. I further understand that my spouse's/domestic partner's group health plan from his/her employer is his/her primary insurance plan. I understand that eligibility for coverage and payment of benefits under the PASSHE plan in all instances is subject to the terms of the plan and that any false or misleading information I provide to the plan regarding the status of any dependent and any other medical or supplemental coverage that may be applicable may result in the suspension or termination of coverage under the plan and may require repayment to the plan of any benefits paid under the plan. I understand that I must inform the plan of any changes in the employment status of any dependents which may affect their eligibility under the plan and that my failure to do so may the loss of coverage and repayment of any amounts paid on their behalf. If my spouse's/domestic partner's dependent and/or eligibility for health care coverage changes, I will notify my University's Human Resources Office immediately. I also understand that I may be required to provide further documentation in the event of a dependent eligibility audit.

I declare that I have read the above certification and that all provided information is correct.

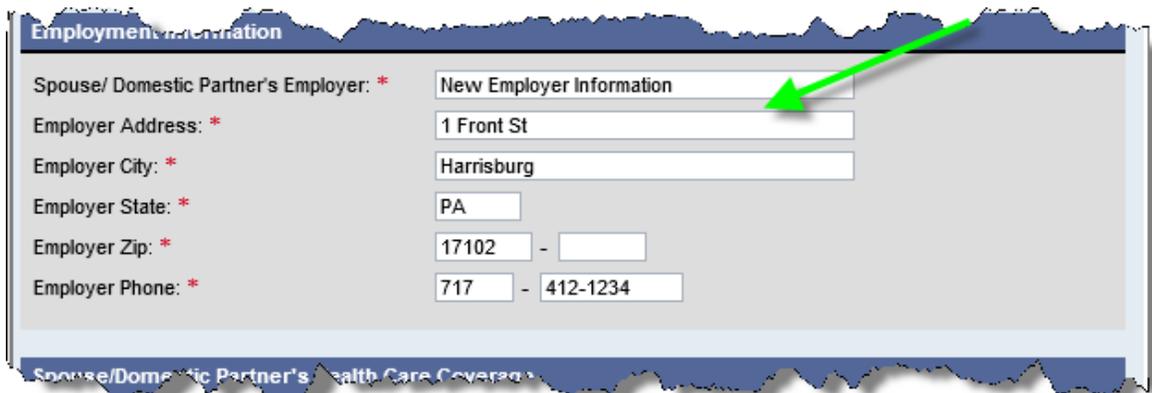
- 5.1. Upon completing Step 5, the employee may receive an email requesting the completion of the Spouse or Domestic Partner Employer Information Form depending upon the information provided during the attestation. Please refer to pages 6 and 7 for a sample of the Spouse or Domestic Partner Employer Information Form as well as additional information regarding the process.
6. If the attestation to be provided does **not** match the current data in the system, choose the “I need to update my spouse/domestic partner health care enrollment attestation”, which will initiate the process to collect new attestation information.



7. As the request for data appears on the screen, provide information by either making selections from drop-down boxes:



Or, provide data by keying it into the system where applicable..



- When all required data has been entered, the “Certification” information section will automatically appear at the bottom of the screen to certify the information provided is true and correct. Click in the “I declare that I have read the above certification and that all provided information is correct” box to agree.

Next, click the “Save my attestation data” button.

The screenshot shows a web form with the following elements:

- Input fields for "ID/Policy Number:" (987654321) and "Policy Effective Date:" (1/1/2019).
- A blue header for the "Certification" section.
- A large text block containing a certification statement: "I declare that all information above is true and correct to the best of my knowledge. If my spouse's/domestic partner's employer offers group health coverage, my spouse/domestic partner must enroll in his/her employer's plan regardless of any cost to my spouse/domestic partner. I understand that if my spouse/domestic partner does not enroll, he/she is ineligible to be covered as a dependent in the PASSHE plan. I further understand that my spouse's/domestic partner's group health plan from his/her employer is his/her primary insurance plan. I understand that eligibility for coverage and payment of benefits under the PASSHE plan in all instances is subject to the terms of the plan and that any false or misleading information I provide to the plan regarding the status of any dependent and any other medical or supplemental coverage that may be applicable may result in the suspension or termination of coverage under the plan and may require repayment to the plan of any benefits paid under the plan. I understand that I must inform the plan of any changes in the employment status of any dependents which may affect their eligibility under the plan and that my failure to do so may result in the loss of coverage and repayment of any amounts paid on their behalf. If my spouse's/domestic partner's employment and/or eligibility for health care coverage changes, I will notify my University's Human Resources Office immediately. I also understand that I may be required to provide further documentation in the event of a dependent eligibility audit."
- A checkbox labeled "1" with a green arrow pointing to it, containing the text: "I declare that I have read the above certification and that all provided information is correct."
- A "Save my attestation data" button with a green arrow pointing to it, labeled "2".

- Upon completing Step 8, the employee may receive an email requesting the completion of the Spouse or Domestic Partner Employer Information Form depending upon the information provided during the attestation. Please refer to pages 6 and 7 for a sample of the Spouse or Domestic Partner Employer Information Form.

**Employer Information Form for Employee Spouse's/Domestic Partner's Employer**

**Audience:** Employees hired on or after 7/1/13 who have a spouse or a domestic partner enrolled in health care coverage through State System and answers provided in the attestation process require additional information to be provided by the spouse's or domestic partner's employer.

**Email Date:** Email is sent to the employee when the spouse or domestic partner attestation has been submitted via ESS and additional information is required from the spouse's or domestic partner's employer.

**Subject:** Spouse/Domestic Partner Attestation – Employer Information Form

**Message Content:**

Thank you for completing the Spouse/Domestic Partner Attestation process via Employee Self-Service. Based upon the information provided in your attestation, your spouse's/domestic partner's employer must complete the Spouse/Domestic Partner Employment Information section of the attached form. An original copy of the completed form must be provided to your university's benefits department by the original due date of the attestation.



Spouse/Domestic Partner – Employer Information Form

State System Employee Name: \_\_\_\_\_
State System Employee Hire Date: \_\_\_\_\_
Spouse/Domestic Partner Name: \_\_\_\_\_

If an employee wishes to enroll his or her spouse or same-sex domestic partner in the PASSHE health plan, and that spouse or partner is eligible for coverage under their own employer's plan, the spouse/partner shall be required to enroll in their own employer's plan as a condition of eligibility for secondary coverage under the PASSHE health plan.

Please complete and submit the form to your university benefits office.

Spouse/Domestic Partner Employment Information (To be completed by the spouse/domestic partner's employer)

Spouse's/Domestic Partner's Employer: \_\_\_\_\_
Employer Address: \_\_\_\_\_
Employer Phone Number: \_\_\_\_\_

Does your organization provide single healthcare coverage at no cost to the employee (i.e. fully employer paid)?
Yes [ ] No [ ]

Is the spouse/partner named above employed in a health benefits eligible position with your organization?
Yes [ ] No [ ]

Is the spouse/partner enrolled in that plan?
Yes [ ] No [ ]

If the spouse/partner is not currently enrolled in your organization's health plan, indicate if you would consider our condition of eligibility for secondary coverage a HIPAA special enrollment event that would allow your employee the opportunity to enroll in your organization's health plan?
Yes [ ] No [ ]

If the question above is no, please list the date of your next open enrollment: \_\_\_\_\_

Name of Employer Representative: \_\_\_\_\_
Signature of Employer Representative: \_\_\_\_\_
Employer Representative Email: \_\_\_\_\_
Employer Representative Phone: \_\_\_\_\_
Date: \_\_\_\_\_

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