FEDERAL SIGNAL
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For HR use:
Opt A: Spouse is eligible for Primary Coverage ❑
Opt B: Spouse is eligible for Secondary Coverage ❑
Opt C: Spouse is eligible for, but not taking, their Employer coverage ❑
($250 per month additional premium applies)

Spouse Medical Plan Eligibility Certification

Who must complete this form? *Employees electing medical coverage for their spouse.*
When must this form be completed? ***Annually*** *during each Open Enrollment period and within 31 days of hire or qualifying event.*

Spouse Eligibility Rules (Select one option below)

❑ **Option A:** If your spouse is not employed or employed but not eligible for medical coverage, and you choose to enroll them in a Federal Signal medical plan, you will pay the regular premium for coverage.

❑ **Option B:** If your spouse is enrolled in his or her employer's medical plan, and you choose to enroll them in a Federal Signal medical plan, you will pay the regular premium for coverage; however the Federal Signal medical plan will be treated as **secondary coverage** for purposes of coordination of benefits.

❑ **Option C:** If your spouse is eligible for coverage through his or her employer but does not enroll for that coverage and you enroll them in a Federal Signal medical plan as primary. A **$250 monthly premium will apply** in addition to the regular premium.

If you selected option A or B, please answer the questions below:

1 Is your spouse employed?
- ❑ No — Stop, sign below and return this form to your Human Resources department. Your spouse may be enrolled in an FS medical plan as their primary coverage.
- ❑ Yes — Answer question #2

2 Is your spouse eligible for medical coverage through their employer?
- ❑ No — You must have the certification located on the reverse of this page completed by your spouse's employer and return it to Human Resources if your spouse is to be enrolled in an FS medical plan.
- ❑ Yes — Answer question #3

3 Will your spouse be covered on their employer's medical plan?
- ❑ No — Your spouse may be enrolled in a FS medical plan. **An additional $250 monthly premium will apply.**
- ❑ Yes — You must have the certification located on the reverse of this page completed by your spouse's employer and return it to Human Resources**.** Your spouse may be enrolled in an FS medical plan as **secondary** coverage only.

You are required to certify your spouse's eligibility each year. If you do not return this form you will pay an additional $250 monthly medical premium until the form is returned and primary medical eligibility is approved.

If the employment status of your spouse changes during the year, their eligibility for coverage under a Federal Signal medical plan may change. You must notify your Human Resources Representative within 31 days of any change in employment status.

I certify that the above information is correct. I understand any misrepresentations constitute fraud and could result in disciplinary action up to and including termination of employment.

_____ _____ _____
Employee Signature | Print Name | Work Location

_____
Date

Return completed form to your Human Resources Representative

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Employer Medical Plan Eligibility Certification

Spouse Authorization

Spouse Name (print): _____

I authorize _____ to release to Federal Signal Corporation the information requested on this form.
Employer

Spouse's Signature: _____ Date: _____

Employer Certification

Completed form must be returned to your employee promptly

Dear Employer:

The Federal Signal Medical Plan requires that a determination be made concerning the eligibility of your employee listed above. The information you provide below will help Federal Signal make this determination. We appreciate your time and assistance.

Please complete the following information as it applies to your employee listed above:

❑ We **do not** offer medical insurance.

❑ We do offer medical insurance, but this employee is not eligible for the following reason: _____

❑ This employee is enrolled in our company's medical insurance as of: _____/_____/_____

❑ This employee is currently eligible to enroll in a medical plan, but is not enrolled for coverage.

Name of person completing this form: _____ Title: _____

Contact Phone: _____ Contact email: _____

Signature: _____ Date: _____