King County

Employee PeopleSoft ID

King County Benefit Access Fee Audit Form

If you are covering a spouse or domestic partner under the King County KingCare PPO medical plan, you are **required** to return this completed form. **Failure to comply with this requirement may result in a Benefit Access Fee being applied (see below) beginning October 1, 2024.**

Employee Benefit group	Benefit Access Fee for KingCare PPO Medical Plan
Regular	$125/month
Transit ATU 587	$150/month
Deputy Sheriff	$100/month
TEA-W2	$90/month

Section 1: Review the information below.

Name **Spouse Name**

Section 2 (REQUIRED): Please choose **ONE** box below which applies to your circumstance.

☐ Yes, a Benefit Access Fee applies, or

No, the Benefit Access Fee does not apply because (check **one** option below):

☐ My spouse/domestic partner's employer does **not** offer medical coverage. You must complete the **Spouse/Domestic Partner Employer Certification** in the box below.

☐ My spouse/domestic partner is not eligible for their employer's medical coverage. You must complete the **Spouse/Domestic Partner Employer Certification** in the box below.

☐ My spouse/domestic partner also works for King County so the Benefit Access Fee does not apply.

☐ My spouse/domestic partner is self-employed or is not employed.

Spouse/Domestic Partner Employer Certification:
(To be completed by a representative of spouse/domestic partner's employer)

By signing below, I am confirming the information selected in Section 2 above is accurate as it pertains to my spouse/domestic partner covered by of the King County employee listed in Section 1 above.

Employer Name: _____ Mailing Address: _____

Phone: _____ Title: _____

Representative Name: _____ Signature: _____

Section 3 (REQUIRED): Sign, date, and return the form.

I certify that the above information is true and accurate to the best of my knowledge. I also understand and agree that in the event any of the statements set forth herein are not true, the insurance coverage for which this form is being submitted may be rescinded and I shall be liable for any expenses incurred by King County.

Employee Signature_____ Date:_____

Please return completed form to the King County Benefits Office:

Email: KC.Benefits@kingcounty.gov
Phone: 206-684-1556
Mailing address: 401 Fifth Ave, CNK-HR-0230, Seattle, WA 98104