Stark County Schools Council of Governments
SPOUSE ELIGIBILITY CERTIFICATION

THIS SECTION TO BE COMPLETED BY THE EMPLOYEE - PLEASE PRINT

EMPLOYEE INFORMATION:

FULL NAME	DISTRICT/ENTITY	SOCIAL SECURITY NUMBER

SPOUSE INFORMATION:

FULL NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

Spouse is: ☐ Not-Employed ☐ Employed ☐ Self-Employed ☐ Retired & Eligible for Benefits: Date _____
☐ Retired & **NOT** Eligible for Benefits

IF NOT EMPLOYED, STOP, sign below and return form. Otherwise, complete and have your spouse's employer, or your spouse if self-employed, complete all applicable sections of this form.

Is group health insurance or prescription drug insurance available to your spouse through his/her employment (whether as a current employee or retiree)? ☐ YES ☐ NO

Regardless of your answer, your spouse must have his/her employer, or your spouse himself/herself if self-employed, complete the Employer Information on the reverse side.

The District/Entity requires that if your spouse is eligible to participate in group health insurance and/or prescription drug insurance through his/her employer, the spouse must enroll in such employer-sponsored group insurance coverage(s). Any spouse who fails to enroll in any such group insurance coverage, as required by this Section, shall be ineligible for benefits under such group insurance coverage sponsored by the District/Entity.

The information contained in this Certification will be utilized in making determination regarding your spouse's eligibility to receive benefits through the District's/Entity's group medical and prescription drug insurance coverage.

Please note it is your responsibility to advise the District/Entity immediately (and no later than 30 days after any change in eligibility) if your spouse becomes eligible to participate in group health insurance and/or prescription drug insurance sponsored by his/her employer after the date you submit this Certification. Upon becoming eligible, your spouse must enroll in such insurance(s) and upon such enrollment by your spouse, the District's/Entity's group insurance will become the secondary payer of benefits.

If you submit false information in this Certificate or fail to timely advise the District/Entity of a change in your spouse's eligibility for employer-sponsored group health insurance and/or prescription drug insurance, and such false information or such failure by you results in the provision of benefits to which your spouse is not entitled, you will be personally liable for reimbursement of benefits and expenses, including attorneys' fees and costs. Any amount to be reimbursed by you may be deducted from the benefits to which you would otherwise be entitled. In addition, your spouse will be terminated immediately from group health insurance and/or prescription drug insurance coverage provided by the District/Entity.

If you submit false information in this Certification, you may be subject to disciplinary action by the District/Entity, up to and including termination of employment.

EMPLOYEE CERTIFICATION:

I HEREBY CERTIFY THAT THE ABOVE EMPLOYEE AND SPOUSE INFORMATION IS CORRECT, and understand that, to ensure benefits are coordinated properly between employers, verification of the accuracy of information will be determined by audits, by contacting my spouse's employer and by contacting me.

EMPLOYEE'S SIGNATURE & DATE (Required) _____ **AREA CODE/PHONE NUMBER** _____

DISTRICT/ENTITY: _____

EMPLOYEE NAME (PRINTED): _____

THIS SECTION TO BE COMPLETED BY THE EMPLOYER OF THE SPOUSE OF THE

DISTRICT/ENTITY _____ **EMPLOYEE**

YOUR
EMPLOYEE'S NAME: _____

EMPLOYER'S NAME: _____

EMPLOYER'S MAILING ADDRESS: _____

_____

	Medical	Prescription
1. Do you offer group insurance to your employees or retirees? Please check Yes or No for each type of coverage listed.	☐ Yes ☐ No	☐ Yes ☐ No
2. Is the spouse listed above eligible for coverage? Number of hours employee works per week (if active) _____	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you offer a Health Savings Account (HSA) plan?	☐ Yes ☐ No	☐ Yes ☐ No
(a) Is this employee/retiree enrolled in the HSA plan?	☐ Yes ☐ No	☐ Yes ☐ No
4. If employee is NOT eligible for coverage, please explain why:		

HEALTH INSURANCE PLAN INFORMATION

PLAN/GROUP # _____ EFFECTIVE DATE OF COVERAGE: _____

INSURANCE COMPANY/TPA NAME: _____

MAILING ADDRESS: _____

SINGLE COVERAGE COST ONLY:

MONTHLY EMPLOYER COST $ _____ MONTHLY EMPLOYEE COST $ _____ OR _____%

PRESCRIPTION DRUG PLAN INFORMATION (If separate from Health Insurance)

PLAN/GROUP # _____ EFFECTIVE DATE OF COVERAGE: _____

INSURANCE COMPANY/PBM NAME: _____

MAILING ADDRESS: _____

SINGLE COVERAGE COST ONLY:

MONTHLY EMPLOYER COST $ _____ MONTHLY EMPLOYEE COST $ _____ OR _____%

EMPLOYER CERTIFICATION

I HEREBY CERTIFY THE ABOVE EMPLOYER AND PLAN INFORMATION IS CORRECT

_____ _____

SPOUSE'S EMPLOYER SIGNATURE **PRINTED NAME AND TITLE**

_____ _____

AREA CODE/PHONE NUMBER **DATE**

ATTENTION EMPLOYEE: PLEASE RETURN COMPLETED CERTIFICATION TO YOUR DISTRICT/ENTITY TREASURER'S OFFICE.