Kent City Schools
Spousal Coordination of Benefits – Eligibility Certification

EMPLOYEE SECTION: This form is to be completed initially then annually if you are covering a spouse as primary on your health plan. PARTIALLY COMPLETED FORMS WILL NOT BE ACCEPTED.

Employee Name: ____

Spouse's Name: ____ Spouse's Date of Birth: ________________

Spouse is: ☐ Employed ☐ Self-Employed ☐ Not Employed ☐ Medicare Eligible

☐ Retired with access to Employer/Retirement Plan-Sponsored Coverage *(includes Non-Medicare eligible retirees)*

☐ Retired without access to Employer/Retirement Plan-Sponsored Coverage *(includes Non-Medicare eligible retirees)*

If you have checked that your spouse is Employed, Self-Employed, or Retired with access to Employer/Retirement Plan-Sponsored coverage, the Spouse's Employer/Retirement System Section below MUST be completed by your spouse's employer, retirement system or by your spouse if he/she is self-employed.

I hereby certify that I am legally married to the above named spouse and that the information provided on the spousal eligibility certification form is accurate and truthful.

_______________________________________ _______________________________

Kent City Schools' Employee Signature Date

SPOUSE'S EMPLOYER/RETIREMENT SYSTEM SECTION:
This section is to be completed by the EMPLOYER or RETIREMENT SYSTEM of the SPOUSE

	Medical	Prescription
1. **Do you offer group (Medical/Drug) insurance to your employees?** 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 your employee works per week** ________	☐ Yes ☐ No	☐ Yes ☐ No
3. **If spouse listed above is NOT eligible for coverage, please explain why:**		
4. **Is spouse listed above currently enrolled OR will he/she be enrolled?** If **yes,** please provide coverage effective date(s):	☐ Yes ☐ No _____________	☐ Yes ☐ No _____________
Provide copy of current ID card or complete the following: a.) Insurance Carrier/Plan Name(s):		
b.) Insurance Carrier/Plan Policy Number(s):		
5. **Does your employee *work less than 20 hours AND is he/she required to pay 50%* or more of the monthly premium for single coverage for any of the Medical plans offered to your employees?** ☐ **Yes** ☐ **No** ________% **Percentage paid by employee**		

SPOUSE'S EMPLOYER/RETIREMENT SYSTEM CERTIFICATION & SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE EMPLOYER AND PLAN INFORMATION IS CORRECT

____ ____________________

Spouse's Employer/Retirement System Signature Date

____ ____________________

Print Name Phone Number

Company/Retirement System Name:____

Street Address: ______________________________City/State/Zip: __________________________

Form must be returned to Tammy Lott, Kent City Schools, 321 N. DePeyster St., Kent OH 44240. Please turn over for important information.

Kent City Schools
Spousal Coordination of Benefits (COB)

If an employee's spouse is eligible to participate, as a current employee, self-employed individual (other than a sole proprietor) in a business or organization (e.g. partner, member), or as a non-Medicare eligible retiree in group health insurance and/or prescription drug insurance sponsored by his/her employer, business, organization, or any retirement plan, the spouse must enroll for at least single coverage in such employer, business, organization, or retirement plan sponsored group insurance coverage(s).

This requirement does not apply to any spouse who:

- **Is not employed and not eligible for non-Medicare retiree group insurance**
- **Works less than 20 hours per week AND is required to pay 50% or more of the single premium to participate in his/her employer's, business', organization's or retirement plan's group health insurance coverage and/or prescription drug insurance.**
- **Is non-working and [1]Medicare eligible.**
- **Is working for an employer with less than 20 employees (includes full time plus full time equivalents) AND is [1]Medicare eligible.**
- **Is retired and eligible for non-Medicare retiree group health insurance and is required to pay 100% of the single premium to participate in his/her retirement plan's group health insurance coverage and/or prescription drug insurance.**

A certification form is required initially for all covered spouses and annually thereafter for all spouses covered as primary by the Kent City Schools' health plan.

Upon the spouse's enrollment in any such employer, business, organization, or retirement plan sponsored group insurance coverage that coverage will become the primary payor of benefits and the coverage sponsored by Kent City Schools will become the secondary payor of benefits according to the primary plan's Coordination of Benefits and participation rules.

Any spouse who fails to enroll in any group insurance coverage sponsored by his/her employer, business, organization, or any retirement plan, as required by this Section, shall be ineligible for benefits under such group insurance coverage sponsored by Kent City Schools.

It is the employee's responsibility to advise the Kent City Schools' Health Benefit Plan (the "Plan") immediately (and not later than 30 days after any change in eligibility) if the employee's spouse becomes eligible to participate in group health insurance and/or prescription drug insurance sponsored by his/her employer, business, organization, or retirement plan. Upon becoming eligible, the employee's spouse must enroll in any group health insurance and/or prescription drug insurance sponsored by his/her employer, business, organization, or retirement plan unless he/she is exempt from this requirement in accordance with the exemptions stated above.

Every employee whose spouse participates in Kent City Schools' group health insurance coverage and/or prescription drug insurance coverage shall complete and submit to the Plan, upon request, a written certification verifying whether his/her spouse is eligible to participate in group health insurance coverage and/or prescription drug insurance coverage sponsored by the spouse's employer, business, organization, or any retirement plan. If any employee fails to complete and submit the certification form by the required date, such employee's spouse will be removed immediately from all group health insurance and/or prescription drug insurance coverage sponsored by Kent City Schools. Additional documentation may be required.

If you submit false information, or fail to timely advise the Plan of a change in your spouse's eligibility for employer (or business, organization, or retirement plan) sponsored group health insurance and/or prescription drug insurance, and such false information or such failure by you results in the Plan providing benefits to which your spouse is not entitled, you will be personally liable to the Plan for reimbursement of benefits and expenses, including attorneys' fees and costs, incurred by the Plan. 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 under the Plan.
Any employee who submits false information may be subject to disciplinary action, up to and including termination of employment.

[1] This material does not address those individuals who are Medicare eligible due to End Stage Renal Disease (ESRD). Please consult the Medicare & You Guide or your local Medicare office for further information.