SCIOTO HEALTH PLAN (SHP)
COORDINATION OF BENEFITS QUESTIONNAIRE

SIDE 1 – SHP MEMBER COMPLETES THIS SIDE FIRST

(Documentation of Spouse's Access to Group Sponsored Medical Coverage)

☐ **Complete this form** - if your spouse is eligible for the SHP Medical/Rx Plan.

SHP Member/Employee _____ SSN: XXX – XX - __ __ __ __

Address _____

School District_____ Building _____

Spouse's Name_____ SSN: XXX – XX - __ __ __ __

My Spouse is: **(Circle all that apply)** Retired Disabled Not Employed Employed

Employed by Another School under the SHP -- DISTRICT _____ (go to bottom of page---sign and return)
Enrolled in another Plan as Primary (go to bottom of page---sign and return)

The SHP Plan requires spouses of covered employees to join their employer's group health plan (on at least an Individual/Single coverage basis) where such eligibility to coverage exists. Your spouse's claims will be considered for COB (Coordination of Benefits) under the SHP Plan. **Claims will not be considered for payment, however, until this form is completed and returned.**

Certain conditions will allow your spouse to be waived from this requirement.

Please Check Appropriate Box (All questions must be answered):

☐Y ☐N My spouse is eligible for group health coverage as an active employee or retired employee eligible for group benefits

☐Y ☐N My spouse's employer or retiree plan requires him/her to pay 50% or greater of the group health plan's Single premium.

If you answered "YES" to either question, skip the following questions.
Your Spouse's employer must complete side 2 of this questionnaire.

☐Y ☐N My spouse is self-employed and does not currently have access to a group medical plan.

☐Y ☐N My spouse is NOT employed and is not eligible to participate in a group retiree plan (Medicare doesn't count)

☐Y ☐N My spouse is retired prior to October 1, 2000 and is not actively employed.

If you answered "Yes" to any of the above questions, your spouse is waived from the Spousal COB requirement for as long as the condition applies. Read and sign the box below and send this form directly to Fred Nelson. (See mailing address on side 2) or attach to your enrollment form.

Employee must read and sign the box below. For self-employed or unemployed spouses, a copy of your prior year's Joint Tax Return and/or copy of your Unemployment check (please black out financial info) must be attached with this form.

SIGNATURE REQUIREMENT – EMPLOYEE ACKNOWLEDGMENT OF COB RESPONSIBILITY:

If my spouse's employment status and/or access to other group coverage changes in the future, I understand that I am responsible for completing an Enrollment form and COB Questionnaire within 31 days of the employment status change. When a spouse retires, the remaining employed spouse must indicate in Section 4 of the Application and Policy Change Form the health insurance plan of the retired spouse. The retired employee may remain on the school health plan, but the school plan would pay second to the retiree's health plan. Failure to notify my employer of my spouse's employment/access change or falsifying my spouse's employment/access status is fraud and will result in financial penalty and/or loss of coverage for my spouse.

Employee Signature_____ Date _____

SIDE 2 – SPOUSE'S EMPLOYER COMPLETES THIS SIDE

Spouse's Employer:
The SHP Plan requires spouses of covered employees to join their employer's group health plan (on at least an Individual/Single coverage basis) or group retiree plan where such eligibility to coverage exists. Please complete the box below in order for your employee's enrollment under the SHP to be considered.

FOR SPOUSAL EMPLOYER USE:

Please check appropriate answer:

☐Y ☐N Is your employee eligible for continuous employer sponsored health coverage through their employment or retirement by you?

☐Y ☐N Is your employee required to pay 50 **percent or LESS** of the total employer premium for their Individual/Single medical coverage?

The above responses are correct to the best of my knowledge.

_____ _____

Employer Representative Date Phone Number Ext.

Company Name & Address_____

Answering No to any question requires supporting documentation on company letterhead be attached, i.e. Plan Document premium contribution amounts, etc.

Answering YES to both of the above questions on this form requires that your employee must be enrolled for primary coverage through your employer/retiree sponsored health plan on at least an Individual/Single basis in order to remain an eligible dependen under the SHP plan. Please provide the information below.

	Medical Carrier	RX (if different from Medical)
Name		
Address 1		
Address 2		
Phone Number		
Policy Number		
Effective Date		
Coverage Level	☐Single ☐Family	☐Single ☐Family

Dependents Covered Under Above Policy	Medical	RX
	☐Yes ☐No	☐Yes ☐No
	☐Yes ☐No	☐Yes ☐No
	☐Yes ☐No	☐Yes ☐No
	☐Yes ☐No	☐Yes ☐No
	☐Yes ☐No	☐Yes ☐No
	☐Yes ☐No	☐Yes ☐No
	☐Yes ☐No	☐Yes ☐No

Direct inquiries and return this form and prior year's joint Tax Return and/or your Unemployment check with financial detail blacked out to:

Scioto Health Plan
Attn: Fred L. Nelson
522 Glenwood Avenue
New Boston, Ohio 45662
Phone Number 740-354-0238 email fred.nelson@scoesc.org