SPOUSE ELIGIBILITY CERTIFICATION
Margaretta Local School District
a member of Huron-Erie School Employee Insurance Association
THIS PAGE TO BE COMPLETED BY MARGARETTA EMPLOYEE – PLEASE PRINT

DISTRICT EMPLOYEE INFORMATION:

_____ (**Please print**)
FULL NAME

SPOUSE INFORMATION:

_____ _____ (**Please print**)
FULL NAME DATE OF BIRTH

My Spouse is (check ***one***): _____ Not employed _____ Employed (including self-employed)
_____ Sole Proprietor _____ Employed by another HESE District (provide name)
Other HESE District _____
Name
_____ Retired _____ _____ Other _____
Date
If retired, Retirement Plan_____
Name

IF YOUR SPOUSE IS NOT EMPLOYED OR IS A SOLE PROPRIETOR, STOP, sign below and return form. Otherwise, complete and have your spouse's employer/retirement plan, or your spouse if self-employed but not a sole proprietor, 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) or retirement plan?*

_____ *YES* _____ *NO*

Regardless of your answer, your spouse must have his/her employer/retirement plan, or your spouse himself/herself if self-employed but not a sole proprietor, complete the Employer/Retirement Plan information on the next page.

The District requires that if your 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 retiree in group health insurance and/or prescription drug insurance sponsored by his/her employer, business, organization, or any retirement plan, your spouse must enroll for coverage in such employer, business, organization, or retirement plan 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. The information contained in this Certification will be utilized in making a determination regarding your spouse's eligibility to receive benefits through the District's group medical and prescription drug insurance coverage.

Please note it is your responsibility to advise the District immediately (and not 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, business, organization or retirement plan 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 group insurance will become the secondary payer of benefits according to the primary plan's coordination of benefits and participation rules. If you submit false information in this Certification or fail to timely advise the District 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 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. **If you submit false information in this Certification, you may be subject to disciplinary action by the District, up to and including termination of employment.**

DISTRICT EMPLOYEE CERTIFICATION:

I HEREBY CERTIFY THAT THE ABOVE EMPLOYEE AND SPOUSE INFORMATION IS CORRECT, and understand that, to ensure benefits are coordinated properly between plans, verification of the accuracy of information will be determined through audits. My spouse's employer/retirement plan and I may be contacted.

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

EMPLOYEE'S FULL NAME (PRINTED): _____

THIS PAGE TO BE COMPLETED BY EMPLOYER/RETIREMENT PLAN OF SPOUSE OF MARGARETTA EMPLOYEE

SPOUSE'S NAME: _____

SPOUSE'S EMPLOYER/RETIREMENT PLAN NAME: _____

SPOUSE'S EMPLOYER/RETIREMENT PLAN MAILING ADDRESS: _____

_____

* Do you offer group health insurance and/or prescription drug insurance (including, but not limited to, insurance requiring employee premium contributions):

(a) To employees? _____ YES _____ NO (b) To retirees? _____ YES _____ NO

Is this spouse (your employee) eligible to participate? _____ YES _____ NO

If no, explain why:

_____

If no, did you pay this spouse (your employee) to waive coverage with you? _____ YES _____ NO

* How many hours per week does this spouse (your employee) regularly work with you? _____

HEALTH INSURANCE PLAN INFORMATION
(for the Plan in which this spouse/your employee is enrolled)

PLAN TYPE: ☐ Traditional, PPO or POS ☐ HMO ☐ HRA ☐ HSA

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/RETIREMENT PLAN CERTIFICATION
I HEREBY CERTIFY THE ABOVE EMPLOYER/RETIREMENT PLAN INFORMATION IS CORRECT.

_____ _____
EMPLOYER/RETIREMENT PLAN SIGNATURE **PRINTED NAME AND TITLE**

_____ _____
AREA CODE/PHONE **DATE**

(11-2021)

ATTENTION MARGARETTA EMPLOYEE: PLEASE RETURN THE COMPLETED CERTIFICATION TO THE TREASURER'S OFFICE.