

Lake Erie Regional Council (LERC)
Working Spouse Eligibility Verification Form
(Must be completed by every Employee who covers a Spouse)

Employee Name: _____	School District: Amherst Exempted Village School District
Spouse Name: _____	Phone #: _____

Part 1 To Be Completed By Employee:

My Spouse is (*click on one*):

- | | |
|---------------------------|---------------|
| Employed by same district | Self-Employed |
| Not Employed | Retired |
| Disabled | |

Amherst Exempted Village School District/LERC's Working Spouse Rule does not apply to items above. If your Spouse meets one of these items, please sign the bottom of this page and return it as required. Part 2 is not required.

OR

Employed Elsewhere
Spouse's Employer must complete Part 2 on back of form.

Please note that your Spouse will not be covered under the Plan unless Part 2 is completed.

By signing this attestation, I certify the accuracy of the above information. I understand that if my Spouse is eligible for health care coverage as an employee through his/her Employer, Business, or Organization **AND** if my Spouse's Employer, Business, or Organization does not complete Part 2, my Spouse will not be eligible for secondary coverage under the Plan.

Employee Signature: _____ Date: ____/____/____

By entering your name electronically on this form you are agreeing that your electronic signature is the legal equivalent of your manual signature.

Please return this form to Amherst Exempted Village School District at the address or email address noted below. If your Spouse is employed elsewhere, you must have his/her Employer, Business, or Organization complete the information in Part 2 on the other side of this form.

Mail to: Haydiee Perkins
Amherst Exempted Village Schools
550 Milan Ave
Amherst, OH 44001
Phone number: (440) 988-1973
Fax number: (440) 988-3700

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Employee Name: _____ School District: Amherst Exempted Village School District

Spouse Name: _____ Phone #: _____

Part 2 To be Completed by Spouse's Employer, Business, or Organization

Amherst Schools has a plan provision that requires Working Spouses to enroll as an employee in their employer's, business', or organization's medical plan if the monthly contribution for single coverage under the lowest cost plan is no more than 25% of the monthly premium cost.

To help us verify whether the Amherst Exempted Village School's Employee will be subject to the Working Spouse Rule, please complete the information below about your employee and return it to him/her accordingly.

1. Do you offer health care coverage to employees? Yes No
(If no, please skip questions 2-6 and sign bottom of the form)

2. Is the employee eligible for health care coverage? Yes No

 If eligible, is employee currently enrolled? Yes No

 If NOT eligible, please provide reason:

 Part-time

 Must complete waiting period

 Other *(please indicate below)*:

3. Total monthly plan cost for lowest cost medical drug plan: \$ _____

4. Employer portion: \$ _____

5. Employee portion: \$ _____

6. Employee contribution: _____ %

Spouse Name: _____

Address: _____

City: _____ State : _____ Zip: _____ Phone Number: _____

Company Benefits Representative Signature: _____

Date: ____ / ____ / ____