THIS DOCUMENT IS FOR INTERNAL PURPOSES ONLY

Francis Howell School District

Spousal Exemption Form for Medical Insurance

This form must be completed by any individual who is requesting medical insurance on their spouse.

THIS FORM MUST BE SUBMITTED ANNUALLY

____________________________ __________________ _____________

Employee's Last Name First Name FHSD ID#

A spouse who has access to and is eligible to be covered under THEIR own employer's medical plan is not eligible for coverage under the Francis Howell Medical Plan.

***Please check the box that describes your affiliation with the District*:** ☐Employee ☐Retiree

My *spouse works for the district* ☐ YES ☐ NO Spouses FHSD ID#____________

If YES, please skip to the acknowledgement statement below, sign and date the form. If NO, continue to the next question.)

Place a check in the correct box to answer the questions relating to your spouse's eligibility for coverage:

1. Is your spouse currently employed? ☐YES ☐NO

   (If NO, please skip to the acknowledgement statement below, sign and date the form. If YES, continue to the next question.)

2. Is your spouse eligible for medical insurance coverage under their current employer's plan?

   ☐YES ☐NO

   (If NO, please skip to the acknowledgement statement below, sign and date the form.)

If the answer to Question #2 is YES, your spouse must enroll in their employer's medical insurance plan.

Should your spouse lose their job or otherwise become ineligible for coverage under their employer's plan, they will be able to enroll under the Francis Howell plan provided we are notified within 30 days of the loss of coverage as required by law. Note: special reenrollment rules apply to retirees; the spousal loss of coverage must meet the definition of an Unanticipated Event in order to enroll a spouse. If your covered spouse currently is not eligible for coverage under an employer plan but becomes eligible at anytime in the future, they will need to enroll in their employer sponsored plan. You must notify FHSD Benefits Office and submit a change form to remove them from the Francis Howell medical insurance plan. In the event the FHSD Benefits Office becomes aware that a spouse has been on the FHSD medical plan while the spouse was eligible for medical coverage through their own employer, the spouse's FHSD coverage will be immediately retroactively terminated to the last determined eligibility date. Premiums paid for the spouse will NOT be refunded to the employee. If determination is made that this coverage decision was made fraudulently, FHSD may take legal action.

My signature below indicates the facts set forth on this form are true and complete to the best of my knowledge. I also understand that if my Spouse's group medical insurance coverage status changes, it is my responsibility to notify FHSD Benefits Office within 30 days of such change.

Signature____Date _____________________

Please Note: The FHSD Benefits Office must receive this form within 30 days of the benefit begin date. Forms not received within said timeframe, will result in spousal medical coverage being denied and retroactively terminated. For Open Enrollment, this form is due by the last day of open enrollment.