

Westlake City School District (District)
A Member of Suburban Health Consortium
Spouse Eligibility/Reimbursement Certification
 (To be completed by the School District Employee – PLEASE PRINT).

1. DISTRICT EMPLOYEE INFORMATION:		
FULL NAME (Employee)	DATE OF BIRTH	MMO ID NUMBER
2. SPOUSE INFORMATION:		
FULL NAME (Spouse)	DATE OF BIRTH	SOCIAL SECURITY NUMBER

Spouse is: Not Employed, not Self-Employed, not Retired Employed or Self-Employed
 Retired on _____ (date) from _____ (employer name) Other _____

If spouse is NOT EMPLOYED, NOT SELF-EMPLOYED, NOT RETIRED, STOP, sign below and return form. Otherwise, complete the rest of this form. Have your spouse's employer, self-employer, former employer or retirement plan [system] complete the appropriate section of this form.

Is group health insurance and/or prescription drug insurance available to your spouse through his/her employment (whether as a current employee, self-employed individual (other than a sole proprietor) in a business or organization (e.g., partner, member), or retiree)? YES NO

Regardless of your answer:

If your spouse is employed, your spouse must have his/her employer, or your spouse, if self-employed, complete section _____ of this form.

If your spouse is retired, (1) have your spouse's former employer/retirement plan [system] complete section _____ of this form, (2) be sure you provided his/her retirement date and the employer from which he/she retired in the space above, sign and date the form.

The District requires that if your spouse is eligible to participate 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 at least single coverage in such employer-sponsored group insurance coverage(s) regardless of cost. Any spouse who fails to enroll in any health and/or prescription drug insurance coverage sponsored by his/her employer, business, organization, or any retirement plan as required by the School District shall be ineligible for such coverage under the Westlake Plan.

3. DISTRICT EMPLOYEE CERTIFICATION:	
I HEREBY CERTIFY THAT I AM NOT MARRIED or I AM LEGALLY MARRIED TO THE ABOVE NAMED SPOUSE AND THAT THE INFORMATION PROVIDED ABOVE IS CORRECT, and understand that, to ensure benefits are coordinated properly between employers, the Plan will verify the accuracy of information by conducting audits, contacting me, and contacting my spouse's employer.	
X	
DISTRICT EMPLOYEE'S SIGNATURE & DATE (Required)	AREA CODE / PHONE NO.