Response Required

Stark County Schools Council (SCSC)

SPOUSE ELIGIBILITY CERTIFICATION

THIS SECTION TO BE COMPLETED BY THE EMPLOYEE - PLEASE PRINT

EMPLOYEE INFORMATION:

FULL NAME	DISTRICT/ENTITY	SOCIAL SECURITY NUMBER

SPOUSE

FULL	DATE OF BIRTH	SOCIAL SECURITY

Spouse is: ☐ Employed ☐ Self-Employed ☐ Retired & Eligible for Benefits: Date _____
☐ Unemployed ☐ Retired & **NOT** Eligible for Benefits

IF SELF EMPLOYED, STOP, sign below and return form. Otherwise, complete and have your spouse's employer, 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)? ☐ YES ☐ NO

Regardless of your answer, your spouse must have his/her employer, complete the Employer Information on the reverse side.

The Stark County Schools' Council (SCSC) requires that if your spouse is eligible to participate in group health insurance and/or prescription drug insurance through his/her employer, the spouse must enroll in such employer-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/Entity.

The information contained in this Certification will be utilized in making determination regarding your spouse's eligibility to receive **primary** benefits through the SCSC group coverage.

If you submit false information in this Certificate or fail to timely advise the District/Entity of a change in your spouse's eligibility for employer-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. In addition, your spouse will be terminated immediately from group health insurance and/or prescription drug insurance coverage provided by the District/Entity.

EMPLOYEE CERTIFICATION:

I HEREBY CERTIFY THAT THE ABOVE EMPLOYEE AND SPOUSE INFORMATION IS CORRECT.

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

DISTRICT/ENTITY: _____

EMPLOYEE NAME (PRINTED): _____

WARNING: *Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.*

Stark County Schools Council (SCSC)

SPOUSE ELIGIBILITY CERTIFICATION

THIS SECTION TO BE COMPLETED BY SPOUSE'S EMPLOYER

YOUR EMPLOYEE'S NAME: _____

EMPLOYER'S NAME: _____

EMPLOYER'S MAILING ADDRESS: _____

	Medical
1. Do you offer group insurance to your employees or retirees?	☐ YES ☐ NO
2. Is the employee listed above eligible for coverage?	☐ YES ☐ NO
3. Do you offer a High Deductible Health Plan (HDHP)/Health Savings Account (HSA) plan?	☐ YES ☐ NO
(a) Is this employee/retiree enrolled in the HSA plan?	☐ YES ☐ NO
(b) Is this the only plan offered by the employer? If yes, no further information required. Please sign and return.	☐ YES ☐ NO
4. If employee is NOT eligible for coverage, please explain why:	
5. Type of coverage. ☐ Single ☐ Family	

6. **SINGLE COVERAGE COST ONLY:**
Monthly Employer Cost $_____ Monthly Employee Cost $_____ OR _____%

7. If **family coverage**, please list names, birth dates and relationship of those covered under the policy. If there is a court order designating responsibility for a child's healthcare, please attach a completed copy of the document with this response.

Last Name	First	MI	Birth Date	Relationship	Court Order Designating Responsibility

8. **HEALTH INSURANCE PLAN INFORMATION**

Status: ☐ Active ☐ Retired ☐ COBRA **Other Policy Covers**: ☐ Medical ☐ Dental ☐ Vision

Group Number: Policyholder Number:

Name of Insurance Company:

EMPLOYER CERTIFICATION

I HEREBY CERTIFY THE ABOVE EMPLOYER AND PLAN INFORMATION IS CORRECT

_____ _____

SPOUSE'S EMPLOYER SIGNATURE **PRINTED NAME AND TITLE**

_____ _____

AREA CODE/PHONE NUMBER **DATE**