

# BUCKEYE SCHOOLS ELIGIBILITY FORM

Working Spouse Coverage –Section 1-Employee Completes this form

Employee Name: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

If unit member's spouse is eligible to participate as a current employee or retiree in group health insurance sponsored by his/her employer or any public retirement plan, the spouse must enroll in such coverage. This requirement does not apply to any employee's spouse who is required to pay more than \$350 of the single monthly premium to participate in his/her employer's group health insurance (or public retirement system) coverage. This provision is for medical/prescription coverage only and does not affect dental or vision coverage. Upon enrollment in any such employer sponsored (or public retirement) plan that coverage will become the primary payer of benefits and the coverage sponsored by the Board will become the secondary payer of benefits. Any other dependents of the District employee are subject to the Birthday Rule (i.e. the dependents will be primary on the coverage of the employee or spouse based on whose birthday falls first in the calendar year).

My spouse is:

Not employed (working spouse language does not apply)

Self-employed and does not have group health insurance (working spouse language does not apply)

(Please provide the name of the company owned by spouse) \_\_\_\_\_

*If any of the above apply, check the applicable box, sign the bottom of form and return to the Treasurer's Office. You do not need to complete the box below or Section 2.*

Employed

Retired or retired under a public retirement system

*If this condition applies, check the box, sign the bottom of form and have spouse's employer complete Section 2.*

**Employee Acknowledgement of Responsibility:** I have read the above information regarding the spousal requirement for medical coverage. I acknowledge the information on this form is accurate to the best of my knowledge. I understand if I submit false information or fail to timely advise the Buckeye Local School District Plan Administrator of a change in the employee's spouse's eligibility for employer (or public retirement plan) sponsored group health insurance and/or prescription drug insurance and such false information or such failure by the employee results in the Buckeye Local School District Base Medical Insurance Plan providing benefits to which the employee's spouse is not entitled, the employee will be personally liable to the Buckeye Local School District for reimbursement of benefits and expenses, including attorneys' fees and costs, incurred by the Buckeye Local School District Medical Insurance Plan. Any amount to be reimbursed by the employee may be deducted from the benefits to which the employee would otherwise be entitled. Falsification may also result in disciplinary action up to and including termination.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# BUCKEYE SCHOOLS ELIGIBILITY FORM

## Working Spouse Coverage Section 2-Completed by Spouse's Employer

Spouse Name:

---

Buckeye Employee:

---

Employer Name or Company:

---

Employer or Company Address:

---

To Whom it May concern:

Buckeye Local School District employees are subject to a working spouse provision. If an employee's spouse is eligible to participate as a current employee or retiree in group health insurance sponsored by his/her employer or any public retirement plan, the spouse must enroll in such coverage. This requirement does not apply to any employee's spouse who is required to pay more than \$350 of the single monthly premium to participate in his/her employer's group health insurance (or public retirement system) coverage.

It has been indicated by our employee that you are the employer of their spouse. Because of our spousal provisions indicated above, additional information is required to make a proper evaluation of the spouse's eligibility. Your assistance in completing the following is appreciated.

1. Do you provide Group Medical Coverage for your employees? Yes No
  1. If Yes, answer Question 2.
  2. If No, please sign, date and return
2. Is the above-named employee eligible to enroll in the Group Medical Program? Yes No
  1. If Yes, answer Question 3.
  2. If No, please indicate why: \_\_\_\_\_ Please sign, date and return.
3. Is the above-named employee required to pay more than \$350 for the single monthly premium (medical/Rx per month) for coverage? Yes No
4. Is the above-named employee covered under this Group Medical Program? Yes No
  1. If Yes, is the plan a High Deductible Health Plan with an HSA Option? Yes No

Authorized Representative:

---

Representative Title:

---

Please return this form to Buckeye Local Schools, 3044 Columbia Road, Medina, OH 44256 or email to the Treasurer's Office at [benefits@buckeyeschools.org](mailto:benefits@buckeyeschools.org)

If you have any questions, please contact the Treasurer's Office at [benefits@buckeyeschools.org](mailto:benefits@buckeyeschools.org).