Conejo Valley Unified School District
750 Mitchell Rd. Newbury Park, California 91362-2198
Telephone (805) 498-4557
Benefits - Risk Management - Business Services

SPOUSE / DOMESTIC PARTNER MEDICAL COVERAGE VERIFICATION

Employee Name: _____

Spouse/Domestic Partner Name: _____

Spouse/Domestic Partner's Employer Name, Address, and Phone number (if applicable):

_____

_____

Reason for adding Spouse/Domestic Partner **(mark one):**
___unemployed ___self-employed___employed without coverage___coveraged & seeking secondary plan

*****Coverage for the reason of having the same insurance as the employee will not be approved*****

Based on chosen reason, provide the appropriate proof required for approval **(employee initial applicable):**

___*Unemployed or self-employed:* my Spouse/Domestic Partner can only obtain single-party medical coverage at a monthly out of pocket cost **higher than $400 per month** through the Open Marketplace (e.g. Covered California) **OR** through a direct carrier plan. I will provide proof of my Spouse/Domestic Partner's full quote from the Open Marketplace or direct carrier plan. I acknowledge my CVUSD plan will be used as sole coverage for my Spouse/Domestic Partner.

___*Employed without coverage:* my Spouse/Domestic Partner can only obtain single-party medical coverage at a monthly out of pocket cost **higher than $400 per month** through their employer's health plan. I will provide proof of my Spouse/ Domestic Partner's employer's available medical plans displaying lowest to highest possible monthly rates **OR** a letter from his/her employer stating insurance is not offered as part of their employment. I acknowledge my CVUSD plan will be used as sole coverage for my Spouse/Domestic Partner.

___*Covered and seeking secondary coverage:* my Spouse/Domestic Partner can obtain single-party medical coverage for **less than $400 per month**. I request enrollment in my chosen CVUSD plan as secondary coverage for my Spouse/Domestic Partner. I will provide proof of primary coverage enrollment from my Spouse/Domestic Partner's current and active plan. I acknowledge my CVUSD plan will only be used as secondary coverage for my Spouse/Domestic Partner.

If your spouse/partner receives a stipend for a cafeteria plan, that stipend must be applied toward single-party medical coverage and may affect approval, proof of cafeteria plan is required.

Certification **(employee initial each):**
___I hereby certify that the above statements are true and correct, and I understand that, to ensure the benefits are coordinated properly, CVUSD may verify the accuracy of information by conducting audits, contacting me, my spouse/ domestic partner's employer, and/or insurance plan. It is fraudulent to knowingly fill out this form with any information that is false.

___I understand that this form must be completed and submitted with any other required information in order to cover my spouse/domestic partner on CVUSD's medical plan. Incomplete forms and/or forms missing participant's and spouse/ domestic partner's signature will be returned. Lack of required proof will result in rejection of enrollment for my spouse/ domestic partner. If any information on this form changes, a new form must be submitted within 30 calendar days.

___I declare under penalty of perjury that all information provided is accurate and I fully understand the spouse/domestic partner eligibility requirements. Failure to provide true and correct information, or failure to report a change in eligibility of a spouse/domestic partner, may result in termination of the employee's health coverage (as well as any covered dependents), and the employee will be reported to Personnel Services for disciplinary action. CVUSD employees are subject to collection for reimbursement of medical costs paid for spouse/domestic partner enrolled in CVUSD medical coverage using fraudulent information.

___I agree to re-submission of verification form as requested by CVUSD annually or as needed and directed by the Benefits Specialist.

Employee: _____ Date: _____

Spouse/Domestic Partner: _____ Date: _____