# SPOUSE ELIGIBILITY CERTIFICATION FOR HEALTH INSURANCE

**THIS SECTION TO BE COMPLETED BY THE EMPLOYEE/PLAN PARTICIPANT - PLEASE PRINT**

**EMPLOYEE/PLAN PARTICIPANT INFORMATION:**

_____ **XXX-XX-**_____

FULL NAME SOCIAL SECURITY NUMBER

**SPOUSE/DOMESTIC PARTNER INFORMATION:**

_____ _____ _____

FULL NAME DATE OF BIRTH SOCIAL SECURITY NUMBER

Please check appropriate information: ☐ Not Employed ☐ Employed ☐ Retired ☐ Other

(Please explain, i.e., Laid-off) _____Date _____

If not employed or retired STOP, sign below and return form. Otherwise, complete and have your spouse's employer/retirement plan, or your spouse if self-employed, 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, or your spouse himself/herself if self employed, complete the Employer Information on the next page.**

The LCS requires that if your spouse is eligible to participate in group health insurance and/or prescription drug insurance, your spouse must enroll in such employer-sponsored or retirement 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 group insurance coverage sponsored by LCS.

The information contained in this Certification will be utilized in making determination regarding your spouse's eligibility to receive benefits through the LCS group medical and prescription drug insurance coverage.

Please note it is your responsibility to advise LCS immediately (and not later than 30 days after any change in eligibility) if your spouse becomes eligible to participate in group health insurance and/or prescription drug insurance sponsored by his/her employer/retirement plan after the date you submit this Certification. Upon becoming eligible, your spouse must enroll in such insurance(s) and upon such enrollment by your spouse, the LCS group insurance will be terminated.

If you submit false information in this Certification or fail to timely advise the LCS of a change in your spouse's eligibility for 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. Any amount to be reimbursed by you may be deducted from the benefits to which you would otherwise be entitled. In addition, your spouse will be terminated immediately from group health insurance and/or prescription drug insurance coverage provided by the LCS.

**If you submit false information in this Certification, you may be subject to disciplinary action by the LCS, up to and including termination of employment.**

## EMPLOYEE/PLAN PARTICIPANT CERTIFICATION:

**I HEREBY CERTIFY THAT THE ABOVE EMPLOYEE/PLAN PARTICIPANT AND SPOUSE INFORMATION IS CORRECT,** and understand that, to ensure benefits are coordinated properly between employers, retirement plans, verification of the accuracy of information will be determined through audits. My spouse's employer, retirement plan and I may be contacted.

_____ _____

**PLAN PARTICIPANT'S SIGNATURE & DATE (Required)** **AREA CODE/PHONE NUMBER**

**Lorain City Schools**

**EMPLOYEE/PLANPARTICIPANT NAME (PRINTED):** _____ **Date:** _____

LORAIN CITY SCHOOLS

# THIS SECTION TO BE COMPLETED BY THE EMPLOYER OF THE SPOUSE

YOUR EMPLOYEE'S NAME: _____ (*spouse of LCS employee*)

EMPLOYER: _____

EMPLOYER PHONE: _____

EMPLOYER MAILING ADDRESS: _____

_____

Do you offer employer-sponsored group health insurance and/or prescription drug insurance including, but not limited to, insurance requiring employee premium contributions:

(a) To employees? ___ YES ___ NO

(b) Is this employee eligible to participate? ___ YES

If no, explain why: _____

(c) Does the employee participate in your insurance plan? ___ YES ___ NO

## HEALTH INSURANCE PLAN INFORMATION

PLAN/GROUP# _____

EFFECTIVE DATE OF COVERAGE (if enrolled): _____

INSURANCE COMPANY/TPA NAME: _____

MAILING ADDRESS: _____

**EMPLOYER CERTIFICATION**
**I HEREBY CERTIFY THE ABOVE EMPLOYER AND PLAN INFORMATION IS CORRECT**

_____ _____

Spouse's ***Employer/Retirement Plan*** SIGNATURE PRINTED NAME AND TITLE

_____ _____ _____

AREA CODE/PHONE EMAIL ADDRESS DATE

***ATTENTION Lorain City Schools Employees***
***Please Return Completed Certification Form to:***
***Sandy Harrell, Benefits Coordinator***
***TREASURER'S OFFICE***
**Phone: 440-830-4052 | Email: saharrell@lorainschools.org**