SPOUSE ELIGIBILITY CERTIFICATION for Health Insurance
Lorain City Schools

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 determinations 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 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:** _____

THIS SECTION TO BE COMPLETED BY THE EMPLOYER OF THE SPOUSE

EMPLOYEE NAME (SPOUSE OF LCS EMPLOYEE): _____

EMPLOYER: _____

EMPLOYER PHONE/ 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 _____NO 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 TO:
Sandy Harrell- Benefits Coordinator-
TREASURER'S OFFICE
440-830-4052 or saharrell@loraincsd.org