WCESC/COG/GOVS 23-24 Spousal Eligibility Rule Form

If you select health insurance coverage for your spouse, you must complete this form.

The spousal rule: Your spouse must enroll in their Employers' group health insurance if the premium contribution is $492.16 or less per month for their least expensive SINGLE health coverage option.

Please include a copy of the Spouses Insurance ID card if Spouse has other coverage and a recent paystub showing premium deduction.

SCHOOL EMPLOYEE This section to be completed by the covered school employee:

Employee Name _____ SSN: Last Four Digits: _____

Circle One:

1. I am married. My spouse is not employed.
2. I am married and my spouse is self-employed with no other coverage available.
3. I am married and my spouse is employed.

EMPLOYED SPOUSE This section to be completed and signed by your spouse if you circled #3 above.

Spouse's Name _____ SSN: Last Four Digits: _____

I authorize my employer to release to my spouse's employer the information requested on this form.

Signature of Spouse: _____ Date: _____

SPOUSE'S EMPLOYER This section to be completed and signed by the Spouse's Employer

The medical plan covering your employee's spouse requires spouses of covered employees to join their employer's group health plan on at least an individual coverage basis. Please circle your responses.

Does your company offer an employer-sponsored health insurance plan? YES NO

Is this employee eligible for employer-sponsored health coverage with your company? YES NO

Is single health insurance available for this employee/retiree at a cost of not more than **$492.16** per month for your least expensive plan? (**Cost to the employee, not total premium**) YES NO

Unless the employee is already covered, you and your employee will be notified if the answers above require that your employee be enrolled for primary coverage through your employer-sponsored health plan. **Thank you for taking the time to complete the information.**

This employee is currently covered or has enrolled in our employer-sponsored health care plan. YES NO

Company Health Insurance Payer/Carrier: _____

Single coverage or Family Coverage Effective Date: _____

Employer Name: _____ Phone: _____ Fax: _____

Signature of Company Benefits Representative: _____ Date: _____

Printed Name of Benefits Representative _____

I declare that the above statements are true:

Employee's Printed Name: _____

Employee's Signature: _____ **Date:** _____

It is the employee's responsibility to advise their employer immediately (within 30 days of change in eligibility) if the employee's spouse becomes eligible to participate in another group health insurance plan. Upon becoming eligible, the employee's spouse must enroll unless he/she is exempt from this requirement in accordance with the exemptions stated above. Any spouse who fails to enroll in any group insurance coverage sponsored by his/her employer, as required by this rule, shall NOT be eligible for benefits under group insurance coverage sponsored by the WCESC/COG/GOVS for the remainder of the calendar year.

PLEASE FAX OR EMAIL THIS FORM TO WARREN COUNTY EDUCATIONAL SERVICE CENTER ATTN: HUMAN RESOURCES
ATTN: Dee - HUMAN RESOURCES DEPARTMENT - FAX 513-695-2961 OR DEE.WILMS@WARRENCOUNTYESC.COM
IF YOU HAVE ANY QUESTIONS, PLEASE CALL 513-695-2900 EX 2920