**SPOUSE ELIGIBILITY CERTIFICATION**

**Cuyahoga Heights Schools**

**a member of the Suburban Health Consortium**

**THIS section to be completed by the Employee/Plan Participant – PLEASE PRINT**

**EMPLOYEE/PLAN PARTICIPANT INFORMATION:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FULL NAME SOCIAL SECURITY NUMBER

**SPOUSE INFORMATION:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FULL NAME DATE OF BIRTH SOCIAL SECURITY NUMBER

Please check appropriate information: \_\_\_\_\_ Not employed \_\_\_\_\_ Employed

\_\_\_\_\_ Retired \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**IF NOT EMPLOYED, STOP, sign below and return form. Otherwise, complete and have your spouse’s employer, 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 District requires that if your spouse is eligible to participate in group health insurance and/or prescription drug insurance, the spouse must enroll in such employer-sponsored 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 such group insurance coverage sponsored by the School District.

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

Please note it is your responsibility to advise the District 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 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 District’s group insurance will become the secondary payer of benefits.

If you submit false information in this Certification or fail to timely advise the District of a change in your spouse’s eligibility for employer-sponsored group 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 District.

**If you submit false information in this Certification, you may be subject to disciplinary action by the District, 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, verification of the accuracy of information will be determined through audits. My spouse’s employer and I may be contacted.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**CUYAHOGA HEIGHTS SCHOOLS**

**EMPLOYEE/PLANPARTICIPANT NAME (PRINTED): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THIS SECTION TO BE COMPLETED BY THE EMPLOYER OF THE SPOUSE OF A**

**CUYAHOGA HEIFHTS SCHOOLS EMPLOYEE**

YOUR **(spouse of Cuyahoga Heights**

EMPLOYEE’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Schools employee)**

EMPLOYER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER’S 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):

1. To employees? \_\_\_\_\_ YES \_\_\_\_\_ NO (b) To retirees? \_\_\_\_\_ YES \_\_\_\_\_ NO

Is this employee eligible to participate? \_\_\_\_\_ YES \_\_\_\_\_ NO

If no, explain why:

Do you offer a Health Savings Account (HSA) plan? \_\_\_\_\_ YES \_\_\_\_\_ NO

1. Is this employee/retiree enrolled in the HSA plan? \_\_\_\_\_ YES \_\_\_\_\_ NO

**Number of hours employee regularly works per week**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH INSURANCE PLAN INFORMATION**

PLAN/GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EFFECTIVE DATE OF COVERAGE: \_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE COMPANY/TPA NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SINGLE COVERAGE COST ONLY:**

MONTHLY EMPLOYER COST $\_\_\_\_\_\_\_\_ MONTHLY EMPLOYEE COST $\_\_\_\_\_\_\_\_\_ or \_\_\_\_\_\_%

**PRESCRIPTION DRUG PLAN INFORMATION** (If separate from Health Insurance)

PLAN/GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EFFECTIVE DATE OF COVERAGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE COMPANY/PBM NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SINGLE COVERAGE COST ONLY:**

MONTHLY EMPLOYER COST $\_\_\_\_\_\_\_\_\_ MONTHLY EMPLOYEE COST $\_\_\_\_\_\_\_\_\_ or \_\_\_\_\_%

**EMPLOYER CERTIFICATION**

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SPOUSE’S EMPLOYER SIGNATURE PRINTED NAME AND TITLE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AREA CODE/PHONE DATE**

***ATTENTION CUYAHOGA HEIGHTS SCHOOLS/PLAN PARTICIPANT: PLEASE RETURN COMPLETED CERTIFICATION TO YOUR DISTRICT TREASURER’S OFFICE.***