TRUMBULL COUNTY SCHOOLS CONSORTIUM

Spouse Coordination of Benefits (COB) Questionnaire Form

Spouses of covered employees who are working full-time are required to join their employer's group health plan for at least single coverage where such availability to coverage exists. ***Your spouse's claim will not be considered for payment until this COB form is completed and returned to the Treasurer's Office.***

Employee Name_____ **SSN**_____

Spouse's Name_____ **SSN**_____

Spouse's Date of Birth_____

Please check the applicable box below.

☐ I do not have a spouse. I carry family coverage for myself and my family. *Sign employee's acknowledgement on page 2*

☐ My spouse is covered under the _____ **Schools** Medical (Medical/Rx) Plan and is:

☐ Unemployed ☐ Self-Employed ☐ With no health insurance available
Sign employee's acknowledgement on page 2

An employee's spouse is deemed to have access to continuous group health insurance coverage when:

1. the spouse can enroll in his/her employer's health insurance plan, or
2. the spouse elects not to enroll in his/her employer's plan but receives a stipend or higher salary, or the spouse could have taken the health plan and not taken the stipend, or
3. the spouse receives a cafeteria or similar plan benefit from the spouse's employer that allows the spouse the choice of health insurance, life insurance, annuity premium or other benefits, or
4. the spouse is the owner, partner, or has a form of proprietary interest in an enterprise that provides no cost health benefits to its employees.

☐ Employed with no available health care benefits. *Sign employee's acknowledgement and spouse's employer must complete form on page2.*

☐ Employed with health care benefits available for less than $250 per month for single coverage. *Sign employee's acknowledgement and spouse's employer must complete form on page 2.* SPOUSE MUST TAKE SINGLE COVERAGE.

☐ Employed with health care benefits available for more than $250 per month for single coverage. *Sign employee's acknowledgement and spouse's employer must complete form on page 2.*

☐ Employed in another Trumbull County Schools Insurance Consortium district. *Sign employee's acknowledgement.*
SPOUSES DATE OF BIRTH _____ SPOUSES DISTRICT _____

☐ Retired receiving no benefits other than Medicare. *Sign employee's acknowledgement.*

☐ Retired with health care **available.** *Sign employee's acknowledgement and spouse's employer must complete form on page2.*

SIGNATURE REQUIREMENT-EMPLOYEE ACKNOWLEDGEMENT;

If my spouse's employment status changes or my marital status changes, I understand I must notify the District Treasurer within 30 days of that change. If an employee or dependent, or anyone acting on behalf of either, makes a false statement or withholds relevant information which results in providing coverage or payment of a claim or claims which would not otherwise have been provided or paid, the employer, its insurer, or assignee may recover from the person responsible or from the person for whom the benefits were paid any amounts wrongfully paid, including legal fees.

Employee's Signature_____ Date: _____

SPOUSE'S EMPLOYER

Spouses of employees of TCSC who are employed and covered by medical care benefits at _____ must join his/her employer's health coverage for single coverage minimally, when such coverage exists. Spouses who are retired must join the retirement system's health care coverage for single coverage minimally when such coverage exists. Please complete the form below in order for your employee's or retiree's claims to be properly handled.

Y N 1. Does your employee have access to healthcare coverage through his/her employment with you?

Y N 2. Does your former employee, if retired, have access to retiree coverage other than Medicare?

Y N 3. Does your employee/retiree have a monthly contribution less than $250.00 per month for single coverage for any health plan available to them?

Company Name _____

Employer Representative (Name/Title) _____

Phone Number _____Ext. _____ Today's Date_____

Answering "Yes" to question #3 requires that your employee **must be** enrolled for primary coverage with you, at least for single coverage, to be an eligible dependent under the school's plan. Please provide the following information:

Subscriber/Employee's Name _____Subscriber ID# _____Group# _____

Name of company's health insurance carrier _____

Carrier's Address _____

Carrier's Phone Number _____

Date of Open Enrollment _____

☐ Single Coverage Medical ☐ RX ☐ Effective Date: _____

☐ Family Coverage Medical ☐ RX ☐ Effective Date: _____

Please contact and/or return form by: **Date** **Name/Address**