STARK COUNTY SCHOOLS COUNCIL OF GOVERNMENTS

SPOUSE ELIGIBILITY CERTIFICATION

THIS SECTION TO BE COMPLETED BY EMPLOYEE—PLEASE PRINT

EMPLOYEE INFORMATION

_____ _____ _____

FULL NAME **DISTRICT/ENTITY** **SOCIAL SECURITY NUMBER**

SPOUSE INFORMATION

_____ _____ _____

FULL NAME **DATE OF BIRTH** **SOCIAL SECURITY NUMBER**

Spouse is: ____Employed ____Self-Employed ____Unemployed

____Employed by another Stark County COG District/Entity_____

Name of District/Entity

IF SPOUSE IS EMPLOYED, have your spouse's employer complete all applicable sections of this form. IF SPOUSE IS SELF-EMPLOYED, STOP and sign below. IF SPOUSE IS EMPLOYED BY ANOTHER COG DISTRICT/ENTITY, their employer does not need to complete the second page of this form. Completed forms need to be uploaded in PlanSource or returned to your benefits office.

The Stark County Schools Council of Governments (COG) requires that if your spouse is eligible to participate in group health insurance and/or prescription drug insurance through their employer, 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 your employer.

The information contained in this Certification will be utilized in making determination regarding your spouse's eligibility to receive **primary** benefits through the COG group coverage.

If you submit false information in this Certificate or fail to timely advise your employer 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. In addition, your spouse will be terminated immediately from group health insurance and/or prescription drug insurance coverage provided by your employer.

EMPLOYEE CERTIFICATION

I HEREBY CERTIFY THAT THE ABOVE EMPLOYEE AND SPOUSE INFORMATION IS CORRECT

_____ _____ _____

Employee's Signature **Date** **Phone**

_____ _____

Employee's Name-Printed **District/Entity**

WARNING:Any person who, with intent to defraud or knowing that they are facilitating fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement is guilty of insurance fraud.

STARK COUNTY SCHOOLS COUNCIL OF GOVERNMENTS

SPOUSE ELIGIBILITY CERTIFICATION

THIS SECTION TO BE COMPLETED BY SPOUSE'S EMPLOYER

YOUR EMPLOYEE'S NAME:_____

EMPLOYER'S NAME:_____

EMPLOYER'S MAILING ADDRESS:_____

1.	Do you offer group Medical insurance to your employees?	____YES	____NO
2.	Is the employee listed above eligible for Medical coverage?	____YES	____NO
3.	Do you offer a Medical High Deductible Health Plan (HDHP)/Health Savings Account (HSA) plan?	____YES	____NO
4.	If there is a HDHP/HSA, is the employee currently enrolled?	____YES	____NO
5.	If you offer Medical insurance other than a HDHP/HSA, does the Employee pay 40% or more of the single premium?	____YES	____NO

6. If employee is NOT eligible for Medical coverage, please explain why:

_____

EMPLOYER CERTIFICATION

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

_____ _____

Spouse's Employer's Signature Printed Name and Title

_____ _____

Area Code/Phone Number Date