

## Xenia Community Schools Spousal Eligibility Verification Form

If a Xenia Community Schools employee's spouse has employer-sponsored health insurance coverage available to him/her through their employer or retirement system, the spouse must enroll in that employer's health insurance coverage. The spouse may remain on Xenia Community School's insurance as secondary coverage, with the employee assuming the deduction for family coverage.

If your spouse is not covered by their employer's health insurance, you must update this form **annually** before he/she can continue to be covered under the Xenia Community School's health insurance plan. If your spouse has insurance available through their employer and does not elect to enroll, the spouse's coverage through Xenia Community Schools will terminate. If you have questions regarding this Eligibility Verification Form, contact Melissa Kraemer in the Treasurer's Office via phone (937-562-9004) or via e-mail (benefits@xeniaschools.org).

If you do not return this form by the deadline, Xenia Community Schools will automatically suspend coverage for your spouse until a completed form is received.

If your spouse becomes eligible for employer coverage at a later date or loses his/her coverage, you are required to complete a new Eligibility Verification Form and submit it to Melissa Kraemer in the Treasurer's Office within 30 days.

### Part A – Employee Completes This Side First

EMPLOYEE: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

Please check only ONE of the following that applies to you:

_____	1.	My spouse is: (Check One)	<input type="checkbox"/> Not employed <input type="checkbox"/> Retired and does not have health insurance through his/her former employer or retirement system <input type="checkbox"/> Self-employed & does not have health insurance
<b>If this section applies, check here &amp; sign bottom of Part A. You <u>do not</u> need to complete Part B</b>			

_____	2.	My spouse is employed and: (Check One)	<input type="checkbox"/> Does not have group health insurance offered to him/her <input type="checkbox"/> Is part-time and not eligible for his/her employer's health insurance <input type="checkbox"/> Covered by his/her employer's health insurance and I am continuing coverage on spouse as secondary under Xenia Community Schools <input type="checkbox"/> Covered by his/her employer's health insurance and I am enrolling my spouse in Xenia Community School's plan as secondary coverage ( <b>online enrollment required</b> )
<b>If true, check here, sign bottom of form and have spouse's employer complete Part B</b>			

_____	3.	My spouse is covered by his/her employer's health insurance:	<input type="checkbox"/> I am terminating coverage effective _____ ( <b>online termination required</b> )
<b>If this section applies, check here &amp; sign bottom of form. You <u>do not</u> need to complete Part B</b>			

### Read below and Sign

Employee Acknowledgement of Responsibility: I have read the above information regarding the spouse requirement for health insurance coverage. I acknowledge that the information on this form is accurate to the best of my knowledge. I understand that if any false statement is made or information withheld, Xenia Community Schools will have the right to recover any overpayment and recoup any legal fees incurred and that health insurance coverage and my employment may be immediately terminated.

Employee Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

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**Part B – To Be Completed by Spouse’s Employer**

Spouse Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

To Whom It May Concern:

If a Xenia Community Schools employee’s spouse has employer-sponsored health insurance coverage available to him/her through their employer, the spouse must enroll in their employer’s health insurance coverage. This also must occur if desiring to be covered by the Xenia Community Schools’ health insurance plan as secondary. If a spouse is not enrolled in their employer’s plan, the spouse’s health insurance coverage through Xenia Community Schools will terminate.

It has been indicated by our employee that you are the employer of their spouse. Because of our spousal provision indicated above, additional information is required to make a proper evaluation of the spouse’s eligibility and/or required monthly contribution. Your assistance in completing the following is appreciated.

1. Do you provide Health Insurance Coverage for your employees? Yes \_\_\_\_\_ No \_\_\_\_\_
  - a. If Yes, answer Question 2
  - b. If you answered No, please sign, date and return.
  
2. Is the above named employee eligible to enroll in this Health Insurance Program? Yes \_\_\_ No \_\_\_
  - a. If Yes, answer Question 3
  - b. If No, please indicate why: \_\_\_\_\_ . Please sign, date and Return.
  
3. Is the above named employee covered under this Health Insurance Program? Yes \_\_\_\_\_ No \_\_\_\_\_
  - a. If Yes, please provide the following information:  
  
Carrier: \_\_\_\_\_ Carrier Phone#: \_\_\_\_\_  
  
Group No.: \_\_\_\_\_ Coverage Effective Date: \_\_\_\_\_
  - b. If No, please provide us with the date of your next open enrollment time period and the effective date.  
Open Enrollment Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

\_\_\_\_\_  
Employer Representative Signature

\_\_\_\_\_  
Date