Mercer-Auglaize Benefit Trust (MABT)

2020 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 or retirement system if the premium contribution is **$338.07** or less per month for their least expensive SINGLE health coverage option.

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. My spouse and I both work at an MABT or Southwestern Ohio EPC school.
3. I am married and my spouse is self-employed with no other coverage available.
4. I am married and my spouse is employed by someone other than an MABT or Southwestern Ohio EPC school.

EMPLOYED SPOUSE This section to be completed and signed by your spouse if you circled #4 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 **$338.07** per month for your least expensive plan? (Cost to the employee, not total premium) YES NO

Please provide the additional information requested and fax this signed form as directed below. 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: _____

I declare that the above statements are true:

Employee's Printed Name: _____

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