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.***[1]

Employee Name_____ **SSN**_____

Spouse's Name_____ **SSN**_____

Spouse's Date of Birth_____

PLEASE CHECK THE APPLICABLE BOX BELOW.

☐ I do not have a spouse and/or I carry coverage for myself and child(ren).

☐ My spouse is covered under the **LABRAE LOCAL SCHOOL DISTRICT** Medical (Medical/Rx) Plan and is:

☐ Unemployed ☐ Self-Employed – Company Name _____

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

- the spouse can enroll in his/her employer's health insurance plan, or
- 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
- 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
- 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 in another Trumbull County Schools Insurance Consortium district.
SPOUSE'S DATE OF BIRTH _____ SPOUSE'S DISTRICT _____

☐ Retired receiving no benefits other than Medicare.

If choosing one of the following options, SPOUSE'S EMPLOYER must complete Page 2.

☐ Employed with no available health care benefits

☐ Employed with health care benefits available for ANY PLAN less than $300 per month for single coverage. SPOUSE MUST TAKE SINGLE COVERAGE.

☐ Employed with health care benefits available for more than $300 per month for single coverage.

☐ Retired with health care **available.**

EMPLOYEE ACKNOWLEDGEMENT [signature required]

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 SIGNATURE_____ **DATE:** _____

[1] Employees are reminded that spouses covered under their employer's HDHP/HSA are **prohibited by federal law** from coordinating benefits with any other health plan.

SPOUSE'S EMPLOYER

LaBrae Employee Name _____

Spouse's Name _____

LaBrae Local Schools employs the spouse of one of your employees. As part of our health care insurance benefit plan, our employees are required to provide information regarding his/her spouse's insurance policy. Spouses of employees of LaBrae who are employed and covered by medical care benefits 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.

Company Name _____

Employer Representative (Name, Title) _____

Employer Representative (Signature) _____

Phone Number _____ Ext. _____ Date_____

YES NO 1. Does your employee have access to healthcare coverage through his/her employment with you?

YES NO 2. Does your former employee, if retired, have access to retiree coverage other than Medicare?

YES NO 3. Does your employee/retiree have a monthly contribution less than $300 per month for single coverage for any health plan available to them?

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 _____

Is this plan a HDHP with an HSA component attached? YES [1] NO

If so, does the employer and/or employee contribute? YES NO

☐ Single Coverage ☐ Medical ☐ RX Effective Date: _____

☐ Family Coverage ☐ Medical ☐ RX Effective Date: _____

Please contact and/or return form ASAP:

LaBrae Local School District
Attention: Jessica Cowger, Assistant to the Treasurer
1001 N. Leavitt Road | Leavittsburg, Ohio 44430
Phone: 330-898-2390 Fax: 330-898-6112
Email: Jessica.Cowger@LaBrae.School

[1] Employees are reminded that spouses covered under their employer's HDHP/HSA are **prohibited by federal law** from coordinating benefits with any other health plan.