HARDIN COUNTY CONSORTIUM
MANDATORY SPOUSE ENROLLMENT CERTIFICATION FORM

Employee Name: _____

Dependent Spouse Name: _____

Please have your spouse complete and identify his / her working status:

- ☐ Employed Full-time (30 hours or more)
- ☐ Employed Part-time (less than 30 hours)
- ☐ Self Employed
- ☐ Not Employed

Please have your spouse complete and identify if his / her employer offers the following:

- ☐ Medical Insurance Coverage
- ☐ Prescription Drug Insurance Coverage

Please have your spouse identify if he / she is enrolled for:

- ☐ Medical Insurance Coverage
- ☐ Prescription Drug Insurance Coverage

I authorize my employer to release this information on my behalf

Signature of Spouse: _____ ***Date:*** _____

To be completed by the spouse's employer:

Dear Employer,

Your cooperation is required to assist in verifying your employee's access to insurance coverage.

Please check ONE appropriate answer:

- ☐ We do not offer group medical and / or prescription drug coverage
- ☐ We offer group medical and prescription drug coverage and the employee is eligible and is enrolled.
- ☐ We offer group medical and prescription drug coverage and the employee is eligible and is not enrolled.
- ☐ We offer group medical and prescription drug coverage and the employee is part-time and is not eligible.

If, employee is eligible and enrolled, please provide the policy number, name of insurance company, and effective date below:

*Medical Policy #*_____ *Insurance Co. Name* _____ *Effective Date* ___ / ___ / ___
Drug Policy # _____ *Insurance co. Name* _____ *Effective Date* ___ / ___ / ___

Please provide the following:

What is the percentage that the employee is required to contribute monthly towards medical / prescription coverage (base plan, employee only)? _____**%.**

How many hours does the employee work per week? _____.

My signature is confirmation that the group benefit plan information I have provided above is true and accurate.

Signature of employer representative: _____ **Date:** _____
Print representative name: _____ **Title:** _____
Print employer name: _____ **Business Phone:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Spousal Coverage Agreement

Hardin County Schools Employee's Health & Welfare Benefit Plan

If an employee's spouse is eligible to participate, as a current employee or retiree in group health insurance and/or prescription drug insurance sponsored by his/her employer or any retirement plan, the spouse must enroll in such employer (or retirement plan) sponsored group insurance coverage(s).

This requirement does not apply to any spouse who is required to pay more than 50% of the single premium to participate in his/her employer's group health insurance coverage and/or prescription drug insurance coverage. This requirement also does not apply to any spouse who is a retiree and enrolled in Medicare coverage.

Upon the spouse's enrollment in any such employer (or retirement plan) sponsored group insurance coverage, that coverage will become the primary payor of benefits and the coverage sponsored by the Board of Education will become the secondary payor of benefits.

Any spouse who fails to enroll in any group insurance coverage sponsored by his/her employer or any retirement plan, as required by this Section, shall be ineligible for benefits under such group insurance coverage sponsored by the Board of Education.

Every employee whose spouse participates in the Board of Education's group health insurance coverage and/or prescription drug insurance coverage shall complete and submit to the Board of Education, upon request, a written certification verifying whether his/her spouse is eligible to participate in group health insurance coverage and/or prescription drug insurance coverage sponsored by the spouse's employer or any retirement plan. If any employee fails to complete and submit the certification form by the required date, such employee's spouse will be removed immediately from all health and prescription drug insurance coverages sponsored by the Board of Education. Additional documentation may be required.

If you submit false information or fail to timely advise the Plan of a change in your spouse's eligibility for employer (or retirement plan) sponsored group health insurance and/or prescription drug insurance, and such false information or such failure by you results in the Plan providing benefits to which your spouse is not entitled, you will be personally liable to the Plan for reimbursement of benefits and expenses, including attorneys' fees and costs, incurred by the Plan. Any amount to be reimbursed by you may be deducted from the benefits to which you would otherwise be entitled. In addition, your spouse will be terminated immediately from group health insurance and/or prescription drug insurance coverage under the Plan. **If you submit false information, you may be subject to disciplinary action by your school district, up to and including termination of employment.**

A school district adopting this Spousal Agreement will receive a 10% discount to its family premium rate(s). The agreement for the adopting school district will be effective the following January 1st upon adoption.

Consortium Approved: May 3, 2013

If two spouses are employed in the same school district or two spouses employed in two different schools in the Hardin County Schools Health Insurance Consortium, then these employees will be exempt from the Spousal Agreement. Amended July 17, 2013