Print Form

EDUCATIONAL SERVICE CENTER OF LORAIN COUNTY
1885 Lake Avenue, Elyria, Ohio 44035
440-324-5777

DEFENSIVE COORDINATOR OF BENEFITS

As part of the ESCLC's insurance benefit plan, there is a Coordination of Benefits policy which states: *If a spouse of an employee has hospitalization, dental and/or vision coverage available through their employer at a cost not to exceed 25% of the single premium cost for each type of coverage, the spouse must participate in their employer coverage as a primary provider.*

Please complete the following information:

ESCLC Employee Name: _____ Spouse's Name: _____

Spouse's Birth Date: _____ Spouse's Social Security #: _____

Spouse's Employer: _____ **If spouse is not employed, you may stop here.**

Address of Employer: _____

Is your spouse currently covered under other hospitalization insurance? ◯ Yes ◯ No If yes, ◯ Single or ◯ Family

If yes, name and address of carrier: _____

Is your spouse currently covered under other dental insurance? ◯ Yes ◯ No If yes, ◯ Single or ◯ Family

If yes, name and address of carrier: _____

Is your spouse currently covered under other vision insurance? ◯ Yes ◯ No If yes, ◯ Single or ◯ Family

If yes, name and address of carrier: _____

Does your spouse have a single hospitalization plan available to him/her at a cost not to exceed 25% of the single premium? ◯ Yes ◯ No

Does your spouse have a single dental plan available to him/her at a cost not to exceed 25% of the single premium? ◯ Yes ◯ No

Does your spouse have a single vision plan available to him/her at a cost not to exceed 25% of the single premium? ◯ Yes ◯ No

If the answer to any of the above is no, then please provide the phone number of your employer and the contact person in charge of benefits for your employer.

Name of Contact Person: _____ Phone Number: _____

If under the Defensive Coordination of Benefits provision, your spouse will now be enrolling for benefits, when is the effective date for benefits to begin?

Hospitalization - Effective Date: _____ Type of hospitalization coverage: ◯ Single or ◯ Family

Name/Address of hospitalization insurance carrier: _____

Dental - Effective Date: _____ Type of hospitalization coverage: ◯ Single or ◯ Family

Name/Address of dental insurance carrier: _____

Vision - Effective Date: _____ Type of hospitalization coverage: ◯ Single or ◯ Family

Name/Address of vision insurance carrier: _____

To the best of my knowledge the above information is true and accurate. I accept that if the information is not accurately stated, the benefits provided to me and my dependents may be reduced. I understand that I am responsible to inform the Treasurer of the Educational Service Center of Lorain County if my spouse becomes eligible for coverage under the conditions of the Defensive Coordination of Benefits provision. I further acknowledge that failure to notify the Treasurer of this eligibility will result in my being responsible for claims paid on behalf of my spouse.

Employee Signature: _____ Date: _____

OFFICE USE ONLY:
Effective Date of Coverage: _____ Effective Date - Dropped from Coverage: _____

Validating Official Name: _____ Date: _____