**SPOUSE ELIGIBILITY CERTIFICATION for Health Insurance**
**Educational Service Center of Lorain County (ESC)**
**a member of Lake Erie Regional Council (LERC)** *June, 2022*

**THIS SECTION TO BE COMPLETED BY THE EMPLOYEE/PLAN PARTICIPANT – PLEASE PRINT**

**EMPLOYEE/PLAN PARTICIPANT INFORMATION:**

_______________________________________ _______________________
FULL NAME SOCIAL SECURITY NUMBER

**SPOUSE/DOMESTIC PARTNER INFORMATION:**

__________________________ _____________ ________________________
FULL NAME DATE OF BIRTH SOCIAL SECURITY NUMBER

Please check appropriate information:____Not employed ____ Employed_____ Retired ______ Other _____
(Please explain, ie. Laid-off) __________________________________ Date ____________________

**IF NOT EMPLOYED, STOP, sign below and return form. Otherwise, complete and have your spouse's employer, or your spouse if self-employed, complete all applicable sections of this form.**

Is group health insurance or prescription drug insurance available to your spouse through his/her employment (whether as a current employee or retiree)?
_____ YES _____ NO

**Regardless of your answer, your spouse must have his/her employer, or your spouse himself/herself if self-employed, complete the Employer Information on the next page.**

The ESC requires that if your spouse is eligible to participate in group health insurance and/or prescription drug insurance, your spouse must enroll in such employer-sponsored group insurance coverage(s). Any spouse who fails to enroll in any such group insurance coverage, as required by this Section, shall be ineligible for benefits under group insurance coverage sponsored by the ESC.

The information contained in this Certification will be utilized in making determination regarding your spouse's eligibility to receive benefits through the ESC's group medical and prescription drug insurance coverage.

Please note it is your responsibility to advise the ESC immediately (and not later than 30 days after any change in eligibility) if your spouse becomes eligible to participate in group health insurance and/or prescription drug insurance sponsored by his/her employer after the date you submit this Certification. Upon becoming eligible, your spouse must enroll in such insurance(s) and upon such enrollment by your spouse, the ESC's group insurance will become the secondary payer of benefits.

If you submit false information in this Certification or fail to timely advise the ESC of a change in your spouse's eligibility for employer-sponsored group health insurance and/or prescription drug insurance, and such false information or such failure by you results in the provision of benefits to which your spouse is not entitled, you will be personally liable for reimbursement of benefits and expenses, including attorneys' fees and costs. 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 provided by the ESC.

**If you submit false information in this Certification, you may be subject to disciplinary action by the ESC, up to and including termination of employment.**

**EMPLOYEE/PLAN PARTICIPANT CERTIFICATION:**

**I HEREBY CERTIFY THAT THE ABOVE EMPLOYEE/PLAN PARTICIPANT AND SPOUSE INFORMATION IS CORRECT,** and understand that, to ensure benefits are coordinated properly between employers, verification of the accuracy of information will be determined through audits. My spouse's employer and I may be contacted.

_________________________________________ ________________________
**PLAN PARTICIPANT'S SIGNATURE & DATE (Required)** **AREA CODE/PHONE NUMBER**

**Educational Service Center of Lorain County**
**EMPLOYEE/PLANPARTICIPANT NAME (PRINTED):** ___________________________ **Date:** __________

**THIS SECTION TO BE COMPLETED BY THE EMPLOYER OF THE SPOUSE of AN Educational Service Center of Lorain County EMPLOYEE**

YOUR EMPLOYEE'S NAME: ____________________________________________________ **(spouse of Educational Service Center of Lorain County employee)**

EMPLOYER'S NAME: ________________________________________________________________

EMPLOYER'S MAILING ADDRESS: ____________________________________________________

____________________________________________________

Do you offer employer-sponsored group health insurance and/or prescription drug insurance (including, but not limited to, insurance requiring employee premium contributions):

(a) To employees? _____ YES _____ NO (b) To retirees? _____ YES _____ NO

Is this employee eligible to participate? _____ YES _____ NO

If no, explain why:

________________________________________________________________________________

Do you offer a Health Savings Account (HSA) plan? _____ YES _____ NO

(a) Is this employee/retiree enrolled in the HSA plan? _____ YES _____ NO
(b) Is an HSA plan the only plan available to this employee? ______YES _____NO

**Number of hours employee regularly works per week**: _________________

**Please provide information on the plan the employee is enrolled. If not enrolled, your lowest cost plan.**

**HEALTH INSURANCE PLAN INFORMATION**

PLAN/GROUP # ___________________________ EFFECTIVE DATE OF COVERAGE (if enrolled): _____________

INSURANCE COMPANY/TPA NAME: ______________________________________________________ HSA Plan yes no

MAILING ADDRESS: ____________________________________________________________________

**SINGLE COVERAGE COST ONLY:**

MONTHLY *EMPLOYER* COST $________ MONTHLY *EMPLOYEE* COST $_________ or ______%

**PRESCRIPTION DRUG PLAN INFORMATION** (If separate from Health Insurance)

PLAN/GROUP # __________________ EFFECTIVE DATE OF COVERAGE: ________________

INSURANCE COMPANY/PBM NAME: ____________________________________________________

MAILING ADDRESS: __________________________________________________________________

**SINGLE COVERAGE COST ONLY:**

MONTHLY *EMPLOYER* COST $_________ MONTHLY EMPLOYEE COST $_________ or _____%

**EMPLOYER CERTIFICATION**
**I HEREBY CERTIFY THE ABOVE EMPLOYER AND PLAN INFORMATION IS CORRECT**

________________________________________ ___________________________________________
**SPOUSE'S EMPLOYER SIGNATURE** **PRINTED NAME AND TITLE**

________________________ __________________________________________ _______________
**AREA CODE/PHONE** **EMAIL ADDRESS** **DATE**

Angela Dotson, Treasurer/CFO ESC 440- 324-5777 ext 1125 or dotson@esclc.org

***ATTENTION Educational Service Center of Lorain County PLAN PARTICIPANT: PLEASE RETURN COMPLETED CERTIFICATION TO YOUR ESC TREASURER'S OFFICE.***