Shaker Heights City School District
Spousal Coordination of Benefits (COB) Certification

INSTRUCTIONS FOR COMPLETION OF SPOUSAL COB CERTIFICATION FORM

This form is to be used for newly enrolling spouses, or if the spouse is on the Shaker plan but has a change in employment or other coverage circumstances.

SECTION 1: Shaker employee completes

SECTION 2: Shaker employee completes

SECTION 3: Spouse's Employer or Retirement Plan/System completes (If applicable)

SECTION 4: Shaker employee and spouse sign/date

INSTRUCTIONS FOR SUBMITTING COMPLETED FORM:
Return your completed form via first class mail, in –person, or interoffice mail to the attention of Nellie Brown in the Human Resources Department. You may also fax to: 216-295-4171 or email to brown_c@shaker.org.

Rev. June, 2021

Shaker Heights City Schools
Spousal Coordination of Benefits (COB) Certification Form
Return to Human Resources

SECTION 1 – SHAKER HEIGHTS CITY SCHOOL EMPLOYEE COMPLETES	
Your Name (print)	
Spouse's Name	
Spouse's Date of Birth	

SECTION 2 – EMPLOYEE CERTIFICATION SECTION – SHAKER EMPLOYEE COMPLETES

Spouse's Employment Status

If your spouse is:

Self-Employed as a Sole Proprietor (B); Not Employed (D); Retired and Medicare Eligible, and not working (E); or Retired, but not Medicare eligible and does not have access to employment-related retirement plan health coverage (G-2), then you & your spouse **sign/date Section 4** and return your completed form to Shaker's Human Resource Department.

If your spouse is:

Employed (A); Self-Employed, but not as a sole proprietor (C); Retired and Medicare-eligible, and Re-employed (F); or Retired, but not Medicare eligible and has access to employment-related retirement plan health coverage (G-1), have your spouse's employer, office administrator or retiree plan administrator **complete Section 3**, then you & your spouse **sign/date Section 4** and return completed form to Shaker's Human Resource Department.

Check the box that applies to your spouse:

(A) Employed ☐

(B) Self-Employed, Sole Proprietor ☐

(C) Self-Employed, Non-sole Proprietor ☐

(D) Not Employed ☐

(E) Retired and Medicare-eligible, and Not Working ☐

(F) Retired and Medicare-eligible, and Re-employed ☐

(G) Retired and NOT Medicare-eligible ☐
(*check below which applies*)

○ (1) With access to Employment-related Retirement Plan Health coverage

○ (2) Without access to Employment-related Retirement Plan Health coverage

(H) Other _____ ☐

Health Savings Account Status

Does your spouse contribute to a Health Savings Account?
____ YES ____NO
Does your spouse's employer contribute to a Health Savings Account on your spouse's behalf? ____YES ____NO

SECTION 3 – SPOUSE'S EMPLOYER (OR RETIREMENT SYSTEM) COMPLETES

Section 3 also applies to self-employed spouses who offer a group insurance plan AND are partners or principals of a corporation, partnership, or proprietorship.

Attention Employer/Health Plan: **Spouses** of Shaker Heights City Schools employees who are eligible for health insurance through their own employment or retirement must be identified and reported to SHCS. Thank you for your prompt assistance.	**Spouse's Name:** _____ **Employer Representative Printed Name and Title:** _____ _____ **Spouse's Employer:** _____ **Phone:** _____ **Address:** _____ **City, State, Zip Code:** _____ **Number of PT/FT Employees:** _____
Employment Status of the Named Shaker Heights City Schools Employee's **Spouse**	□ W-2 employee, full-time □ W-2 employee, part-time □ 1099 contract employee □ Other _____ □ Number of Hours this spouse works per week for your firm: _____
Benefit Eligibility Status of the Named Shaker Heights City Schools Employee's **Spouse** (Check All Applicable Options)	□ Spouse is enrolled in our medical/drug insurance plan. **Please provide**: **Carrier Name:** _____ **Group Policy Number:** _____ **Effective Date of Coverage:** _____ □ Spouse is eligible for, but not enrolled in, our medical/drug plan. □ Spouse declined coverage at last annual open or special enrollment. □ Spouse is not eligible for our medical/drug insurance plan. If not eligible, state reason: _____. □ Our organization does not offer a medical/drug insurance plan. □ Other _____
Medical/Drug insurance coverage Information applicable to named **Spouse** (*Please complete whether or not named spouse is enrolled in your plan)*	□ What is the monthly employee premium contribution for single coverage under your medical/drug plan? $_____ □ Is the employee premium contribution more than 50% of the total single premium for your medical/drug plan? ____YES ____NO □ When is your firm's annual open enrollment period, and what is the effective date of coverage? _____
I certify that the statements I made here are complete and accurate.	Spouse's employer representative: **Sign:** **Date:**

SECTION 4: EMPLOYEE AND SPOUSE SIGN THIS DECLARATION OF ACCURACY		
We certify that the statements made here are complete and accurate as of today's date. A Shaker employee who submits false information may be subject to disciplinary action, up to and including termination of employment, and/or loss of spouse's eligibility for coverage under the Shaker plan.		
Signature of Employee	Sign	Date
Signature of Spouse	Sign	Date

Shaker Heights City Schools
Spousal Coordination of Benefits (COB)

If an employee's spouse is eligible to participate, as a current employee, self-employed individual (other than a sole proprietor) in a business or organization (e.g. partner, member), or as a non-Medicare eligible retiree in group health insurance and/or prescription drug insurance sponsored by his/her employer, business, organization, or any retirement plan, the spouse must enroll for at least single coverage in such employer, business, organization, or retirement plan sponsored group insurance coverage(s)) no later than the date enrolled in the Shaker plan (if not already enrolled in such).

This requirement does not apply to any spouse who does not have access to an employment-related retirement health plan coverage AND who:

- Is not employed, retired or otherwise not working;
- Is employed, but not eligible for coverage under his/her employer's plan;
- Is employed, but works less than 30 hours per week AND is required to pay more than 50% of the single premium to participate in his/her employer's, business', organization's or retirement plan's group health and/or prescription drug insurance;
- Is self-employed as a sole-proprietor;
- Is non-working and [1]Medicare eligible; or
- Is working for an employer with less than 20 employees (includes part-time, full-time plus full time equivalents) AND is [1]Medicare eligible.

A certification form is required initially for all covered spouses and may be required periodically when it's determined that an audit will be conducted. Every employee whose spouse participates in the Shaker Heights City School District (SHCSD) group health insurance plan (medical and prescription drug) shall complete and submit to SHCSD, 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, enterprise or public or private

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 coverage sponsored b the Board.

Upon the spouse's enrollment in such group insurance coverage, that coverage will become the primary payor of benefits and the Shaker Heights City School District (SHCSD) Plan will become the secondary payor of benefits, except where contrary to law.

Any spouse who fails to enroll in any group insurance coverage sponsored by the spouse's employer, enterprise or any public or private retirement plan, as required by this Agreement, shall be ineligible for benefits under the SHCSD group health insurance plan**.**

Changes to spouse's employment and/or other coverage status: It is the employee's responsibility to advise the Shaker Heights City Schools' Health Benefit Plan (the "Plan") immediately (and not later than 30 days after any change in eligibility) if the employee's spouse becomes eligible to participate in group health insurance and/or prescription drug insurance sponsored by his/her employer, business, organization, or retirement plan after his/her initial enrollment date in the Shaker plan. Upon becoming eligible, the employee's spouse must enroll in any group health insurance and/or prescription drug insurance sponsored by his/her employer, business, organization, or retirement plan unless he/she is exempt from this requirement in accordance with the exemptions stated above.

If an employee submits false information or fails to timely advise SHCSD of a change in the spouse's eligibility for employer, enterprise or retirement plan sponsored group health insurance and prescription drug insurance and such false information, or such failure results in the SHCSD Plan providing benefits to which the spouse is not entitled, the employee will be personally liable to SHCSD for reimbursement of benefits and expenses incurred by the SHCSD Plan. Any amount to be reimbursed by the employee may be by direct payment by the employee or, if not, shall be deducted through payroll deduction.

[1] *This material does not address those individuals who are Medicare eligible due to End Stage Renal Disease (ESRD). Please consult the Medicare & You Guide or your local Medicare office for further information.*

Spouse Health and Prescription Insurance Card Submission Form

STEP 1 – SHAKER HEIGHTS CITY SCHOOLS EMPLOYEE COMPLETES THIS SECTION	
Your Name (print)	
Your Non-Work Telephone Number	
Name of Spouse	

In order to provide Coordination of Benefits information to the Shaker Heights Health Plan, please submit a clear, legible copy of your spouse's medical/drug insurance card in the spaces below.

If prescription drug plan has a separate card, please provide a copy of both medical and prescription drug cards.

Place front of card here

Place back of card here

What is the effective date of coverage? _____

Additional Notes

_____

_____

_____

TIPS

- ✓ Make a photocopy of the front and back of the card.
- ✓ Cut out the photocopies, and tape securely to the form in the spaces indicated.

STEP 2 – EMPLOYEE AND SPOUSE SIGN THIS DECLARATION OF ACCURACY	
We certify that the information provided in this document is complete and accurate as of today's date. We understand that any statements made on this form may be confirmed and verified by independent third-party researchers. We understand that the penalties for submitting inaccurate information may include the loss of spouse coverage.	
Signature of Employee	Sign Date
Signature of Spouse	Sign Date

Please return this completed form to Shaker's Human Resource Department.