Working Spouse Health Coverage Verification Form (Spousal COB)

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

STEP 2 – SPOUSE'S EMPLOYER (OR RETIREMENT SYSTEM) COMPLETES THIS SECTION	
Attention Employer: **Spouses** of Shaker Heights City Schools employees who do not have their own medical insurance plan through their own employment must be identified and reported to SHCS. Thank you for your prompt assistance.	Print Name _____ Title _____ Organization _____ Phone _____ Address _____ City, State, Zip Code _____ *Affix your business card here.* *Or provide your contact information if a business card is not available.*
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) Medical/Drug insurance coverage Information applicable to named **Spouse**	□ Spouse is enrolled in our medical/drug insurance plan. □ 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: _____. □ This organization does not offer a medical/drug insurance plan. □ Other _____ □ What is the monthly employee premium contribution for single coverage under your medical/drug plan? $_____ □ What is the total monthly premium cost for single coverage under your medical/drug plan? $_____ (employee + employer amount) □ 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 as of today's date.	Sign Date

The Step 2 certification section also applies to self-employed spouses who offer a group insurance plan AND partners or principals of a corporation, partnership, or proprietorship.

STEP 3 – 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.	
Health Savings Account Information	**Does your spouse contribute to a Health Savings Account? Does your spouse's employer contribute to a Health Savings Account on your spouse's behalf?**
Signature of Employee	Sign Date
Signature of Spouse	Sign Date

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

Rev. 7/18