SHAKER HEIGHTS CITY SCHOOL DISTRICT
Shaker Heights, Ohio

1234567

Affidavit of Spousal Health Care Coverage

______________________________ Employee SSN: ______________________________

Name of Spouse: ______________________________ Spouse Date of Birth: ______________________________

Important: please ensure this form is fully completed and signed and dated by Shaker Heights CSD employee. Your response, or lack of response, will impact your spouse's health care coverage.

SECTION I: Spouse Employment Information

1. Is your spouse currently employed?
   - □ Yes (continue to Section II)
   - □ Self-employed with group healthcare plan available (continue to Section II)
   - □ Self-employed with no group healthcare plan available (continue to Section IV)
   - □ Not employed / Not Retired (continue to Section IV)
   - □ Retired (continue to question 2)
2. If your spouse is Retired, check one of the following that applies to your spouse:
   - □ Retired, NOT Medicare eligible, but eligible for a group retirement health plan (continue to Section II)
   - □ Retired/Medicare eligible (continue to question 3)
3. If your spouse is Retired and Medicare eligible, check one of the following that applies to your spouse:
   - □ NOT Enrolled in Medicare or a Medicare Supplement (continue to Section IV)
   - □ Enrolled in Medicare or a Medicare Supplement (continue to question 4)
4. If enrolled please provide Medicare or Medicare Supplement ID #: ______________________ (continue to Section IV)

SECTION II: Spouse's Employer or Retiree Group Plan Section: This section must be completed by your spouse's employer or retiree health plan.

	MEDICAL	PRESCRIPTION
1. Do you offer group insurance to your employees or retirees? **(If yes continue to question 2; if no continue to Section III)**	□ Yes □ No	□ Yes □ No
2. Is the spouse named above eligible for employee or retiree health benefits through your company? **(If yes continue to question 4, if no continue to question 3)**	□ Yes □ No	□ Yes □ No
3. If not eligible, please explain why? **(continue to Section III)**		
4. Is the spouse enrolled in health care coverage? **(If yes continue to question 6, if no continue to question 5)**	□ Yes □ No	□ Yes □ No
5. If eligible, but not enrolled, please explain why? **(answer questions 6 through 13)**		
6. If spouse is enrolled, please provide coverage effective dates? **(answer questions 7 through 13)**		
7. What is the total monthly premium for single coverage?	$	$
8. What is the spouse's / retiree's contribution for the cost of single coverage? **(% or $ amount)**	$	$
9. Number of hours the spouse named above works per week?		
10. Medical /Prescription Drug Carrier or Plan Name		
11. Policy Number		
12. When is your company's open enrollment period?		
13. Do you offer COBRA continuation to terminated employees? **(continue to Section III)**	□ Yes	□ No

See reverse side to complete (over) →

Section III: Spouse's Employer or Retiree Group Plan Section: This section must be completed by your spouse's employer or retiree health plan.

Name of employer: ____

Address of employer: ____
Number and Street | City | State | Zip

Name of Representative (Printed): ______________________ Phone: (   ) ______________

Signature of Representative: ____

Title: ______________________________________ Date: ______________

Section IV: Acknowledgement – must be signed by above-named Shaker Heights CSD Employee

I hereby certify that I am legally married to the above named spouse and that the information provided on the affidavit of spousal health care coverage is accurate and truthful. I understand that, to ensure benefits are coordinated properly between plans, the Plan will verify the accuracy of information by conducting audits, contacting me and my spouse's employer.

______________________________________ ______________________
Employee Signature *(required)* Date

Return the completed, signed affidavit to Shaker Heights City Schools Benefits/HR Office.

Keep a copy of the completed affidavit and fax confirmation for your records.