MCSEIC

Mahoning County School Employees Insurance Consortium

West Branch Local School District

Coordination of Benefits (COB) Questionnaire Form

Spouses of covered employees who are working full-time are required to join their employer's group health plan for at least single coverage where such availability to coverage exists at a cost of $300 or less. Your spouse's claim will not be considered for payment until this COB form is completed and returned to the Treasurer's Office.

Member:_____ **SSN**_____

Spouse's Name_____ **SSN**_____

Please check the applicable box below.

My spouse is covered under the **West Branch Local School District's** Medical (Medical/Rx) Plan and is:

___ Unemployed. ____ Self-Employed with no health insurance available.
Sign acknowledgement below.

An employee's spouse is deemed to have access to continuous group health insurance coverage when:

1. the spouse can enroll in his/her employer's health insurance plan, or
2. the spouse elects not to enroll in his/her employer's plan but receives a stipend or higher salary, or the spouse could have taken the health plan and not taken the stipend, or
3. the spouse receives a cafeteria or similar plan benefit from the spouse's employer that allows the spouse the choice of health insurance, life insurance, annuity premium or other benefits, or
4. the spouse is the owner, partner, or has a form of proprietary interest in an enterprise that provides no cost health benefits to its employees.

____ Employed less than 20 hours per week on average over a 12-month period. (10-month period for a school district employee) *Sign employee's acknowledgement.*

____ Employed over 20 hours per week with no available health care benefits. *Sign employee's acknowledgement and spouse's employer must complete form on page2.*

____ Employed over 20 hours per week with health care benefits available for less that $300 per month for single coverage. *Sign employee's acknowledgement and spouse's employer must complete form on page 2.*

____ Employed-available health care benefits cost over $300 per month for single coverage. *Sign employee's acknowledgement and spouse's employer must complete form on page 2.*

____ Employed by the West Branch School District. *Sign employee's acknowledgement.*

____ Retired receiving no benefits other than Medicare. Spouse retired from_____
_____. *Sign employee's acknowledgement.*

____ Retired with health care **available.** *Sign employee's acknowledgement and spouse's employer must complete form on page2.*

SIGNATURE REQUIREMENT-EMPLOYEE ACKNOWLEDGEMENT;

If my spouse's employment status changes, I understand I must notify the District Treasurer within 30 days of that change. If an employee or dependent, or anyone acting on behalf of either, makes a false statement or withholds relevant information which results in providing coverage or payment of a claim or claims which would not otherwise have been provided or paid, the employer, its insurer, or assignee may recover from the person responsible or from the person for whom the benefits were paid any amounts wrongfully paid, including legal fees.

Employee's Signature_____ Date:_____

SPOUSE'S EMPLOYER

Spouses of employees of MCSEIC who are employed full-time and covered by medical care benefits at **West Branch Local School District** must join his/her employer's health coverage for single coverage (Medical/RX) minimally, when such coverage exists for $300 or less for their share. Spouses who are retired must join the retirement system's health care coverage for single coverage (Medical/RX) minimally when such coverage exists. Please complete the form below in order for your employee's or retiree's claims to be properly handled.

Y N 1. Does your employee have access to healthcare coverage through his/her employment with you and is single coverage available at a monthly cost of $300 or less?

Y N 2. Does your employee work a minimum of 20 hours a week on average over a 12 month period? (10 –month period for a school district employee)

Y N 3. Does your former employee, if retired, have access to retiree coverage other than Medicare?

Company Name _____Employer Representative (Name/Title)_____

Phone Number _____Ext. _____ Today's Date_____

Answering "Yes" to the above questions requires that your employee **must be** enrolled for primary coverage with you, at least for single coverage, to be an eligible dependent under the school's plan. Please provide the following information:

Name of company's health insurance carrier/payor _____

Subscriber/Employee's Name _____Subscriber ID# _____Group# _____

{ } Single Coverage Medical RX Effective Date: _____

{ } Family Coverage Medical RX Effective Date: _____

Please contact and/or return form to:

West Branch Local Schools
14277 Main St
Beloit, OH 44609
(330) 938-4447
Att: Karen Rice

For employees adding spouses to plan mid-year because of a change in circumstances: This form must be completed and returned before coverage will begin for employee's spouse.