

**SCHOOL EMPLOYEE** This section to be completed by the covered school employee:

Employee Name: \_\_\_\_\_

SSN: Last Four Digits: \_\_\_\_\_

**Circle one:**

- 1. I am single.
- 2. I am married. My spouse is not employed.
- 3. I am married. My spouse and I both work at an MABT school.
- 4. I am married. My spouse is self-employed and does not offer insurance to employees.
- 5. I am married and my spouse is employed by someone other than an MABT school.

If you circled one of the numbers #1 through 3, sign and date here this form to the Treasurer's office. No further action is necessary at this time. If you circled #5, your spouse's employer must complete this form.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Your signature above acknowledges that you understand you are obligated to notify your district treasurer within 30 days of a change in your spousal employment status. Failure to do so could result in a loss of coverage for your spouse.

**Please sign and date above and have your spouse take this form to his/her employer.**

**EMPLOYED SPOUSE** This section to be completed and signed by your spouse if you checked #4 above.

Spouse's Name: \_\_\_\_\_

SSN: Last Four Digits: \_\_\_\_\_

I authorize my employer to release to my spouse's employer the information requested on this form.

Signature of Spouse: \_\_\_\_\_

Date: \_\_\_\_\_

**SPOUSE'S EMPLOYER** This section to be completed and signed by the Spouse's Employer

The medical plan covering your employee's spouse requires spouses of covered employees to join their employer's group health plan on at least an individual coverage basis. Please circle your responses.

- Does your company offer an employer-sponsored health insurance plan? **YES** **NO**
- Does your company offer an H.S.A. employer-sponsored health insurance plan? **YES** **NO**
- If Yes,** is the H.S.A. the only plan offered? **YES** **NO**
- Is this employee eligible for employer-sponsored health coverage with your company? **YES** **NO**
- Is this employee required to contribute less than 50% of the total premium for the least expensive single Medical plan in order to be covered by your plan? **YES** **NO**

Please provide the additional information requested and fax this signed form as directed below. Unless the employee is already covered, you and your employee will be notified if the answers above require that your employee be enrolled for primary coverage through your employer-sponsored health plan. **Thank you for taking the time to complete the information.**

This employee is currently covered or has enrolled in our employer-sponsored health care plan. **YES** **NO**

Company Health Insurance Payer/Carrier: \_\_\_\_\_

Circle one: Single coverage for your employee Family Coverage Effective Date: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Signature of Company Benefits Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**Employer: Please fax this form to ( ) \_\_\_\_\_ on or before \_\_\_\_\_**

Helen Uhlenhake, Assistant Treasurer, St. Henry Consolidated Local Schools

If you have questions, please call ( ) \_\_\_\_\_, ext. \_\_\_\_\_