Side One

# Union County Health Insurance Benefits Plan
## Annual Eligibility Certification for Plan Year 2014
## Spousal Eligibility Certificate

Union County's COB (Coordination of Benefits) requires spouses of covered employees to join their Employer's group health plan for primary coverage where such availability to coverage exists. Spouse's claims will not be considered for payment until this Certificate is completed and returned to the Auditor's office during open enrollment of each year. Also, secondary coverage for spouses will no longer be allowed under the county's plan.

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Union County Employee Name _____ SSN# (last 4 digits) _____
(print)

Department Name_____ Phone# _____

Please check the one item that qualifies the employee's spouse as eligible for coverage as a dependent on Union County's Health Insurance Plan:

☐ 1. My spouse is *self*-employed and does not currently have access to a group medical plan.

☐ 2. My spouse is employed and my spouse's Employer does NOT offer medical coverage for my spouse or my spouse does not meet his/her Employer's medical insurance eligibility requirements.

☐ 3. My spouse is retired, is not actively employed, and does not have access to a group medical/dental/prescription plan through a public/private retirement plan.

☐ 4. My spouse is also employed by Union County.

☐ 5. My spouse is not employed.

**AFFIDAVIT**: I understand that my spouse must meet the eligibility requirements to qualify for enrollment as my dependent in the Union County Health Insurance Benefits Plan. I attest that the facts above are true and correct to the best of my knowledge and indicate this by my signature below. I understand that if my spouse's coverage status changes, it is my obligation to inform the Auditor's Office within 30 days of any change. Any false statements as it relates to this information shall be considered grounds for disciplinary action.

**Employee's Signature: _____ Date: _____**

**If Item 2 above is checked above, the county employee, spouse and spouse's Employer shall complete Side 2 of the Certificate in order for the spouse's medical claims to be considered.**

Side Two

# Union County Employees Health Insurance Benefits Plan
## Annual Eligibility Certification for Plan Year 2014
## Spousal Eligibility Certificate

SPOUSE EMPLOYER VERIFICATION OF COVERAGE

**If Item 2 of Side 1 of the Spousal Eligibility Certificate is checked, the county employee, spouse and spouse's Employer shall complete Side 2 of the Certificate in order for the spouse's medical claims to be considered.**

**Union County Employee Name:** _____ **SSN# (last 4 digits):** _____
(printed)

**Department Name**:_____ **Phone#**: _____

**I authorize my Employer to release the health care plan coverage information requested below.**

**Spouse name (printed): _____**

**Spouse Signature: _____ Date: _____**

**The medical plan covering your employee's spouse requires spouses eligible for coverage under another Employer-sponsored plan to take that coverage as primary.**

| | | |
|---|---|---|
| Does your company offer an Employer-sponsored health insurance plan? | Yes | No |
| Is this employee eligible for Employer-sponsored health insurance coverage with your company? | Yes | No |

**(If both answers are marked yes, then the employee's spouse shall be covered under their Employer-sponsored plan)**

**If this employee is currently covered or enrolled in the Employer-sponsored plan, please complete the following:**

Company Health Insurance Carrier: _____

Coverage (circle one): Individual Family Other: _____ Effective Date: _____

Employer Name: _____ Phone: _____

Authorized Employer Contact Signature: _____ Date: _____

Printed Name and Title: _____

**If you have questions, call 937-645-3063. Please return this form to Lindsay Altizer, Auditor's Office.**
**Fax: 937-645-3057; E-mail:** laltizer@co.union.oh.us