Greater Cincinnati Insurance Consortium Health Plan (GCIC)
District:_____
Spousal Coordination of Benefits – Eligibility Certification

EMPLOYEE SECTION: This form is to be completed initially and annually at open enrollment if you are covering a spouse on your health plan. PARTIALLY COMPLETED FORMS WILL NOT BE ACCEPTED.

Employee Name: _____ SSN#_____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse is: ☐ Employed ☐ Self-Employed ☐ Employed by another GCIC District:_____
☐ Retired with access to Employer-Sponsored Coverage ☐ Retired without access to Employer-Sponsored Coverage
☐ Not-Employed ☐ Not-Employed and Medicare Eligible

If you have checked that your spouse is Employed, Self-Employed, or Retired with access to Employer-Sponsored coverage, the Spouse's Employer Section below MUST be completed by your spouse's employer or by your spouse if he/she is self-employed.

I hereby certify that I am legally married to the above named spouse and that the information provided on the spousal eligibility certification form is accurate and truthful.

_____ _____
GCIC District Employee Signature Date

SPOUSE'S EMPLOYER SECTION: This section is to be completed by the EMPLOYER of the SPOUSE

	Medical	Prescription
1. **Do you offer group insurance to your employees?** Please check Yes or No for each type of coverage listed.	☐ Yes ☐ No	☐ Yes ☐ No
2. **Is the spouse listed above eligible for coverage?** **Number of hours employee works per week _____**	☐ Yes ☐ No	☐ Yes ☐ No
3. **If employee is NOT eligible for coverage, please explain why:**		
4. **Is employee currently enrolled or will he/she be enrolled?** If **yes,** please provide coverage effective date(s):	☐ Yes ☐ No _____	☐ Yes ☐ No _____
Provide copy of current ID card or complete the following: a.) Insurance Carrier/Plan Name(s):		
b.) Insurance Carrier/Plan Policy Number(s):		
5. **Does your employee *work less than 20 hours AND is he/she required to pay more than 50%* of the monthly premium for single coverage for any of the Medical plans offered to your employees?** ☐ **Yes** ☐ **No** **_____% Percentage paid by employee**		

SPOUSE'S EMPLOYER CERTIFICATION & SIGNATURE

I HEREBY CERTIFY THAT THE ABOVE EMPLOYER AND PLAN INFORMATION IS CORRECT

_____ _____
Spouse's Employer Signature Date

_____ _____
Print Name Phone Number

Company Name: _____

Street Address: _____City/State/Zip: _____

Form must be returned to_____ by _____. Please turn over for important information.

Greater Cincinnati Insurance Consortium (GCIC)
Spouse Coordination of Benefits (COB)
Effective January 1, 2014

If an employee's spouse is eligible to participate, as a current employee, self-employed individual (other than a sole proprietor) in a business or organization (e.g. partner, member), or retiree in group health insurance and/or prescription drug insurance sponsored by his/her employer, business, organization, or any retirement plan, the spouse must enroll for at least single coverage in such employer, business, organization, or retirement plan sponsored group insurance coverage(s) no later than January 1, 2014.

This requirement does not apply to any spouse who:

- **Is not employed and [1]Medicare eligible.**
- **Is employed by another GCIC district.**
- **Works less than 20 hours per week AND is required to pay more than 50% of the single premium to participate in his/her employer's, business', organization's or retirement plan's group health insurance coverage and/or prescription drug insurance.**
- **Is employed by an employer with less than 20 employees (includes full-time plus full-time equivalents) AND is [1]Medicare eligible.**

A certification form is required annually for all spouses covered as primary by the GCIC health plan.

Upon the spouse's enrollment in any such employer, business, organization, or retirement plan sponsored group insurance coverage that coverage will become the primary payor of benefits and the coverage sponsored by GCIC will become the secondary payor of benefits according to the primary plan's Coordination of Benefits and participation rules.

Any spouse who fails to enroll in any group insurance coverage sponsored by his/her employer, business, organization, or any retirement plan, as required by this Section, shall be ineligible for benefits under such group insurance coverage sponsored by GCIC.

It is the employee's responsibility to advise the GCIC Health Benefit Plan (the "Plan") immediately (and not later than 30 days after any change in eligibility) if the employee's spouse becomes eligible to participate in group health insurance and/or prescription drug insurance sponsored by his/her employer, business, organization, or retirement plan after January 1, 2014. Upon becoming eligible, the employee's spouse must enroll in any group health insurance and/or prescription drug insurance sponsored by his/her employer, business, organization, or retirement plan unless he/she is exempt from this requirement in accordance with the exemptions stated above.

Every employee whose spouse participates in GCIC's group health insurance coverage and/or prescription drug insurance coverage shall complete and submit to the Plan, upon request, a written certification verifying whether his/her spouse is eligible to participate in group health insurance coverage and/or prescription drug insurance coverage sponsored by the spouse's employer, business, organization, or any retirement plan. If any employee fails to complete and submit the certification form by the required date, such employee's spouse will be removed immediately from all group health insurance and/or prescription drug insurance coverage sponsored by GCIC. Additional documentation may be required.

If you submit false information, or fail to timely advise the Plan of a change in your spouse's eligibility for employer (or business, organization, or retirement plan) sponsored group health insurance and/or prescription drug insurance, and such false information or such failure by you results in the Plan providing benefits to which your spouse is not entitled, you will be personally liable to the Plan for reimbursement of benefits and expenses, including attorneys' fees and costs, incurred by the Plan. Any amount to be reimbursed by you may be deducted from the benefits to which you would otherwise be entitled. In addition, your spouse will be terminated immediately from group health insurance and/or prescription drug insurance coverage under the Plan.

[1] This material does not address those individuals who are Medicare eligible due to End Stage Renal Disease (ESRD). Please consult the Medicare & You Guide or your local Medicare office for further information.