Findlay City Schools
Spousal Coordination of Benefits Policy

Effective September 1, 2011 employee spouses who are employed by employers other than Findlay City Schools MUST enroll in the health insurance program made available through their employer if an employer-sponsored group health plan is available when certain conditions are met.

A spouse is required to participate in their employer-sponsored health care plan if: 1) they have access to continuous (i.e., non-seasonal) group health coverage through his/her employment, and 2) the employee contribution cost to any available plan is less than **$190 per month**.

If these conditions are met, your spouse must enroll in their employer's health care plan. If your spouse is eligible for coverage through their employer and does not take that coverage, he/she is not eligible for coverage under the Findlay City Schools plan.

If your spouse is self-employed and does not have access to group health coverage, or if your spouse is not working or is not eligible for coverage through their employer, then he/she is eligible to participate in the Findlay City Schools health plan. If your spouse must wait until an open enrollment period to enroll for coverage under his/her employer's plan, he/she is required to enroll in the employer's plan during its next open enrollment period. In the meantime, your spouse will be eligible to participate in the Findlay City Schools plan.

You will need to indicate whether your spouse is eligible for other employer-sponsored healthcare coverage. You will be asked to certify that your spouse has coverage and to provide information about that coverage or to certify that his or her employer does not offer medical coverage. If you do not respond or are untruthful, your health insurance may be terminated.

Please sign the certification below and if applicable have the spouse's employer sign also.

I hereby certify that my spouse, _____, (**print spouse name**) is:

1 ☐ not employed, and I will inform the Treasurer's office whenever he/she becomes employed. (No Spouse Employer signature needed)

2 ☐ eligible for health insurance coverage at _____(print name of spouse employer) and will move to that coverage as soon as it is available on this date ___/___/_____. (No Spouse Employer signature needed)

3 ☐ employed, but company does not offer health insurance to any employees.

4 ☐ employed, but is not eligible for health insurance.

5 ☐ employed, but there is no available plan for where the employee contribution is less than **$190 per month**. The available plan with the lowest employee contribution costs the employee $_____per month.*

I will inform the Treasurer's office whenever a plan becomes available for less than $190 per month.

_____
FCS Employee Signature & Date

_____
Spouse Employer Signature* (Sign and Print), Title & Date (needed if box three, four, or five is checked) * indicates box five statement and lowest employee contribution info is accurate as of this date

_____
FCS Employee Printed Name

_____(___)_____
Spouse's Employer Company Name and Phone Number

8/9/2011
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Revised 7/8/21
Revised 6/27/22