

# TRUMBULL COUNTY SCHOOLS CONSORTIUM

## Spouse 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. ***Your spouse's claim will not be considered for payment until this COB form is completed and returned to the Treasurer's Office.<sup>1</sup>***

Employee Name \_\_\_\_\_ SSN \_\_\_\_\_

Spouse's Name \_\_\_\_\_ SSN \_\_\_\_\_

Spouse's Date of Birth \_\_\_\_\_

Please check the applicable box below.

- I do not have a spouse. I carry family coverage for myself and my family. Sign employee's acknowledgement on page 2
- My spouse is covered under the \_\_\_\_\_ Schools Medical (Medical/Rx) Plan and is:
- Unemployed                       Self-Employed                       With no health insurance available  
Sign employee's acknowledgement on page 2

**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 with no available health care benefits. Sign employee's acknowledgement and spouse's employer must complete form on page 2.

Employed with health care benefits available for \$250 or less per month for single coverage. Sign employee's acknowledgement and spouse's employer must complete form on page 2. SPOUSE MUST TAKE SINGLE COVERAGE.

Employed with health care benefits available for more than \$250 per month for single coverage. Sign employee's acknowledgement and spouse's employer must complete form on page 2.

Employed in another Trumbull County Schools Insurance Consortium district. Sign employee's acknowledgement.  
SPOUSE'S DATE OF BIRTH \_\_\_\_\_ SPOUSE'S DISTRICT \_\_\_\_\_

Retired receiving no benefits other than Medicare. Sign employee's acknowledgement.

Retired with health care **available**. Sign employee's acknowledgement and spouse's employer must complete form on page 2.

<sup>1</sup> Employees are reminded that spouses covered under their employer's HDHP/HSA are prohibited by federal law from coordinating benefits with any other health plan.

