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.***[1]

Employee Name_____ **SSN**_____

Spouse's Name_____ **SSN**_____

Spouse's Date of Birth_____

PLEASE CHECK THE APPLICABLE BOX BELOW.

☐ I do not have a spouse and/or I carry family coverage for myself and family.

☐ My spouse is covered under the _____ **Schools** Medical (Medical/Rx) Plan and is:

☐ Unemployed ☐ Self-Employed ☐ With no health insurance available

An employee's spouse is deemed to have access to continuous group health insurance coverage when:

- the spouse can enroll in his/her employer's health insurance plan, or
- 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
- 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
- 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 in another Trumbull County Schools Insurance Consortium district.

SPOUSE'S DATE OF BIRTH _____ SPOUSE'S DISTRICT _____

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

If choosing one of the following options, SPOUSE'S EMPLOYER must complete Page 2.

☐ Employed with no available health care benefits

☐ Employed with health care benefits available for $250 or less per month for single coverage. SPOUSE MUST TAKE SINGLE COVERAGE.

☐ Employed with health care benefits available for more than $250 per month for single coverage.

☐ Retired with health care **available.**

EMPLOYEE ACKNOWLEDGEMENT [signature required]

If my spouse's employment status changes or my marital status changes, I understand I must notify the District Treasurer within 30 days of that change. If an employee or dependent, or anyone acting on behalf of either, makes a false statement or withholds relevant information which results in providing coverage or payment of a claim or claims which would not otherwise have been provided or paid, the employer, its insurer, or assignee may recover from the person responsible or from the person for whom the benefits were paid any amounts wrongfully paid, including legal fees.

EMPLOYEE SIGNATURE_____ **DATE:** _____

[1] 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.

[Revised 10/2024]

SPOUSE'S EMPLOYER

Spouses of employees of TCSC who are employed and covered by medical care benefits at **LABRAE LOCAL SCHOOL DISTRICT** must join his/her employer's health coverage for single coverage minimally, when such coverage exists. Spouses who are retired must join the retirement system's health care coverage for single coverage minimally when such coverage exists.

Please complete the form below in order for your employee's or retiree's claims to be properly handled.

Company Name _____

Employer Representative (Name, Title) _____

Phone Number _____ Ext. _____ Date_____

YES NO 1. Does your employee have access to healthcare coverage through his/her employment with you?

YES NO 2. Does your former employee, if retired, have access to retiree coverage other than Medicare?

YES NO 3. Does your employee/retiree have a monthly contribution LESS THAN $250 per month for **single coverage for any health plan available to them?**

Answering "Yes" to question #3 requires that your employee **must be** enrolled for primary coverage with you, at least for single coverage, to be an eligible dependent under the school's plan. Please provide the following information:

Subscriber/Employee's Name _____

Subscriber ID# _____ Group# _____

Name of Company's Health Insurance Carrier _____

Carrier's Address _____

Carrier's Phone Number _____

Date of Open Enrollment _____

Is this plan a HDHP with an HSA component attached? YES NO

If so, does the employer and/or employee contribute? YES NO

☐ Single Coverage ☐ Medical ☐ RX Effective Date: _____

☐ Family Coverage ☐ Medical ☐ RX Effective Date: _____

Please return form by: **November 15, 2024**

LaBrae Local School District
Jessica Cowger, Assistant Treasurer
1001 N. Leavitt Road | Leavittsburg, Ohio 44430
330-898-2390

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[Revised 10/2024]