Warren City School (WCS) District 2015
Annual Spouse Eligibility Certification for WCS Employees

(To be *completed by the Employee* – PLEASE PRINT)

WCS DISTRICT EMPLOYEE INFORMATION		
FULL NAME	AREA CODE / PHONE NUMBER	SOCIAL SECURITY #
		XXX-XX-
SPOUSE INFORMATION		
FULL NAME	DATE OF BIRTH	SOCIAL SECURITY #
		XXX-XX-

My spouse is: ☐ Not Employed ☐ Employed ☐ Receiving Medicare
☐ Not Retired ☐ Retirement Date: _____ (attach a copy of Medicare card)

* If your Spouse is NOT EMPLOYED and NOT RETIRED and not eligible for non-medicare government health benefits, STOP, sign on the bottom of this form and return form.

* If your Spouse is RECEIVING MEDICARE coverage, STOP, sign on the bottom of this form, attach a copy of the Medicare card and return form.

Does your spouse have group medical, prescription drug, dental and/or vision insurance available through his/her employment, retirement system or non-medicare government health benefit program?

Medical	☐	YES	☐	NO
Prescription Drug	☐	YES	☐	NO
Dental	☐	YES	☐	NO
Vision	☐	YES	☐	NO

WCS DISTRICT EMPLOYEE ELECTION & AUTHORIZATION

I ELECT HEALTH COVERAGE FOR MY SPOUSE AS FOLLOWS:

☐ My spouse DOES NOT have coverage available or offered through his/her employer or retirement system or other non-governmental health benefit plan OR my spouse is self-employed and therefore I will NOT be required to pay a monthly spousal fee.

☐ My spouse IS NOT enrolled in his/her available employer or retirement system or other non-government health, prescription drug, dental and/or vision coverage. I understand my spouse will remain as a covered dependent under the WCS District plan and that I will pay the applicable spousal fee as determined by my current contract language per month by payroll deduction for my spouse's primary coverage. (Employer Verification NOT required for this option)

☐ My spouse is ENROLLED in his/her employer's or retirement system's or other non-governmental health benefit plan with the following coverage: ____Medical ____ Prescription Drug ____ Dental ____ Vision. His/Her effective date on those plans was _____. I understand that my spouse will remain as a covered dependent under the WCS plan as secondary to his/her coverage.

WCS DISTRICT EMPLOYEE CERTIFICATION

I HEREBY CERTIFY THAT THE EMPLOYEE AND SPOUSE INFORMATION ON THIS FORM IS CORRECT and understand that, to ensure benefits are coordinated properly between employers and plans, WCS District will verify the accuracy of information by conducting audits, contacting me, and contacting my spouse's employer or retirement plan. I further certify my election and authorization above.

WCS Employee Name (PRINT)	*WCS Employee Signature* (REQUIRED)	*Date*

Your spouse MUST have his/her employer or retirement system complete the Verification information on the reverse side of this form. Please note: WCS employees must timely notify the WCS Plan of a change in their spouse's eligibility for employer-sponsored group insurance coverage. Failure to timely notify is considered the equivalent of falsification of the certification form.