University of Findlay – Spousal Coordination of Benefits

1000 North Main Street Findlay, OH 45840

To University of Findlay Employees:
A spouse of a University of Findlay employee is required to participate in his/her employer sponsored health care plan if: the spouse has access to continuous group health coverage through his/her employment, and the employer contributes at least 50 percent of the premium. If these conditions are met, the spouse must enroll in his/her employer's health care plan. The spouse will be permitted to remain on the University of Findlay plan for secondary health care coverage.

University of Findlay Employee: _____ T# _____
(PLEASE PRINT)

University of Findlay Employee Signature: _____
(I understand that any willful misrepresentation of fact on the form will be grounds for termination of benefits as well as Insurance Fraud. I hereby certify that the foregoing information is true and correct.)

Is your spouse (please check one): Self Employed – Name of company_____

Employed Disabled Retired Unemployed

If your spouse is Employed please have the rest of this form completed by his/her HR department.

To Whom It May Concern:

It has been indicated by our health plan participant that you are the employer of the below named person. Because of the coordination of benefits provision contained in the University of Findlay health plan, additional information is required to make a proper evaluation of the coverage available to your employee. Your assistance in completing this form is appreciated.

Your Employee: _____ Last 4 numbers of SSN#: _____

Do you offer health care coverage to your employees? Yes No

Is this employee eligible for health care coverage as your employee? Yes No

Is this employee covered under your health care coverage? Yes No

If No, please list reason: _____

If No, what is the next earliest date the employee can enroll?_____

If Yes, what date did the coverage start? _____

If Yes, are his/her dependents covered? Yes No

If Yes, what is the monthly premium paid by the employee: $_____

Do you or will you pay 50 percent or more of the employee's health premium? Yes No

If No, what percent of the health premium do you pay? _____

If no longer employed, please provide the date health coverage terminated: _____

_____ _____
Name (PLEASE PRINT) Date

_____ _____
Title Phone number

Employer/Company Name _____