MIAMI COUNTY EDUCATIONAL SERVICE CENTER
SPOUSAL CARVE OUT FORM

I. This Section to be Completed by Employee of the Miami County ESC

Employee's Name _____

_____ My spouse is not employed at this time.
I understand that if my spouse becomes employed in the future, it is my responsibility to request and complete a new form within 30 days of their employment. Please sign below and no further action is required at this time.

_____ My spouse is employed at this time. Please sign and continue to the box below.

Employee Signature: _____ Date: _____

You are responsible for completing and returning this form to the Human Resources Coordinator at the time of election.

II. This Section to be Completed and Signed by Employed Spouse

Spouse's Name: _____ SSN: _____

I authorize my employer to release to the Miami County ESC the information requested on this form.

Spouse's Signature: _____ Date: _____

III. This Section to be Completed by Spouse's Employer

The Miami County ESC Health Benefit Plan requires that a determination be made concerning the eligibility of a spouse for coverage. The information you provide below will help us make this determination. We appreciate your time and help in this matter.

For your information. The Miami County ESC has adopted a Spousal Carve Out Rule which requires an employed spouse of an employee of the school district to enroll for single coverage in the medical plan offered by or through his or her employer. If a spouse is eligible for coverage through their employer and chooses not to enroll, he or she is not eligible to enroll in the Miami County ESC Health Benefit Plan.

As a reminder, if your plan is governed by Section 125 regulations, loss of coverage is generally recognized as a status change. In any event, HIPAA regulations require a special enrollment period for individuals who previously declined coverage for themselves and their dependents without having to wait until the plan's next open enrollment period. A special enrollment period occurs if a person with other health insurance coverage loses that coverage.

Please complete the following applicable information on your employee:

_____ Type of coverage and date coverage began or will begin:
____ Medical Date: _____

_____ We offer medical insurance but this employee is not eligible to enroll because:
_____

_____ We do not offer medical insurance.

Employer Name: _____

Signature of Company Benefits Representative: _____

Phone: _____ Date: _____