Clermont County Insurance Consortium Health Plan (CCIC) District: Grant CC
Spousal Coordination of Benefits – Eligibility Certification

EMPLOYEE SECTION: This form is to be completed initially and annually at open enrollment if you are covering a spouse on your health plan. **Partially completed forms will not be accepted.**

Include copy of Spouse's insurance ID card if Spouse has other coverage

CCIC Employee's Name _____Date_____

Spouse's Name _____

Check all that Apply

Spouse is:

(If any of the below apply YOU MUST have spouse's employer complete the employer section below)

- ☐ Employed
- ☐ Self Employed
- ☐ Retired *with* access to Employer/Retirement Plan-Sponsored Coverage

(**If any of the below apply you DO NOT need to have the employer section below completed)**

- ☐ Not Employed
- ☐ Retired *without* access to Employer/Retirement Plan-Sponsored Coverage
- ☐ Is Medicare Eligible
- ☐ Employed by a CCIC District (*List district name)* _____

I hereby certify that I am legally married to the above-named spouse and that the information provided on the spousal eligibility certification form is accurate and truthful.

CCIC Employee's Signature _____Date _____

EMPLOYER / RETIREMENT SECTION: To be completed by the Employer or Retirement System of the spouse.

1. Do you offer group medical/prescription drug insurance? ☐ Yes ☐ No
2. Is the spouse listed above eligible for coverage? ☐ Yes ☐ No
3. If the spouse is not eligible for coverage, please explain why:

_____

4. Is the spouse currently enrolled **OR** will he/she be enrolled? ☐ Yes ☐ No

If yes, provide current **OR** future coverage effective date(s):_____

NAME OF INSURANCE CARRIER: _____ Group #_____

Spouse's Employer/Retirement System Certification and Signature

I hereby certify that the above employer/retirement system information is correct.

Spouse's Employer/Retirement System _____

Signature _____

Print Name _____Date_____

Phone Number_____

Company/Retirement System Name _____

Address _____