

If you select health insurance coverage for your spouse, you must complete this form.

The spousal rule: Your spouse must enroll in their Employers' group health insurance or retirement system if the premium contribution is \$284.96 or less per month for their least expensive SINGLE health coverage option.

SCHOOL EMPLOYEE This section to be completed by the covered school employee:	
Employee Name _____ SSN: Last Four Digits: _____	
Circle One:	<ol style="list-style-type: none">1. I am married. My spouse is not employed.2. I am married. My spouse and I both work at a MABT school.3. I am married and my spouse is self-employed with no other coverage available.4. I am married and my spouse is employed by someone other than an MABT school.

EMPLOYED SPOUSE This section to be completed and signed by your spouse if you checked #4 above.	
Spouse's Name _____ SSN: Last Four Digits: _____	
I authorize my employer to release to my spouse's employer the information requested on this form.	
Signature of Spouse: _____	Date: _____

SPOUSE'S EMPLOYER This section to be completed and signed by the Spouse's Employer		
The medical plan covering your employee's spouse requires spouses of covered employees to join their employer's group health plan on at least an individual coverage basis. <u>Please circle your responses.</u>		
Does your company offer an employer-sponsored health insurance plan?	YES	NO
Is this employee eligible for employer-sponsored health coverage with your company?	YES	NO
Is single health insurance available for this employee/retiree at a cost of not more than \$284.96 per month for your least expensive option? (Cost to the employee, not total premium)	YES	NO
Please provide the additional information requested and fax this signed form as directed below. Unless the employee is already covered, you and your employee will be notified if the answers above require that your employee be enrolled for primary coverage through your employer-sponsored health plan. Thank you for taking the time to complete the information.		
This employee is currently covered or has enrolled in our employer-sponsored health care plan.	YES	NO
Company Health Insurance Payer/Carrier: _____		
Single coverage	Family Coverage	Effective Date: _____
Employer Name: _____	Phone: _____	FAX: _____
Signature of Company Benefits Representative: _____	Date: _____	

I declare that the above statements are true:

Employee's Printed Name: _____

Employee's Signature: _____ **Date:** _____

Return to: Celina City Schools Treasurer's Office
Attn: Scott Braun
585 E Livingston Street
Celina, OH 45822

Fax# 419-586-7046