OBERLIN COLLEGE & CONSERVATORY | Department of Human Resources

2025 Spousal Coordination of Benefits Form

To Oberlin College Employees:

A spouse of an Oberlin College employee is required to participate in their employer sponsored health care plan if: the spouse has access to continuous group health coverage through their employment, and the employer contributes at least 50 percent of the premium. If these conditions are met, the spouse must enroll in their employer's health care plan.

Oberlin College Employee (PLEASE PRINT): _____ T# _____

Employee Classification (PLEASE CHECK ONE): ☐ OCOPE ☐ SEC ☐ UAW ☐ A&PS ☐ FAC ☐ CONF

Name of Spouse (PLEASE PRINT): _____

Is your spouse (PLEASE CHECK ONE) ☐ Self Employed – Name of company _____

☐ Employed ☐ Employed by Oberlin College ☐ Disabled ☐ Retired ☐ Unemployed

Oberlin College 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.)

If your spouse is employed, please have the rest of this form completed by their 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 Oberlin College 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? _____

If Yes, what is the monthly premium paid by the employee's health premium? _____

Do you or will you pay 50 percent or more of the employee's health premium? _____

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

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

Name/Title (PLEASE PRINT) _____ Date _____

Signature _____ Phone Number _____

Employer/Company Name _____

Employee Only: Upload form with supporting documentation to an HR submission folder. Click on the number for link.

(1) Qualifying Event (2) New Hire (3) Open Enrollment