Oberlin College – Spousal Coordination of Benefits

173 West Lorain Street, Oberlin, OH 44074

To Oberlin College Employees:

A spouse/domestic partner of an Oberlin College employee is required to participate in his/her employer sponsored health care plan if: the spouse/domestic partner 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/domestic partner must enroll in his/her employer's health care plan. The spouse/domestic partner will be permitted to remain on the Oberlin College health plan for secondary health care coverage.

Oberlin College Employee: ________________________________ T# _____________________
(PLEASE PRINT)

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.)

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 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? 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 ____