

2026 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