Oberlin College – 2021 Spousal Coordination of Benefits Form

Please return completed form to: Human Resources, 173 West Lorain Street, Oberlin, OH 44074 or by email to human.resources@oberlin.edu

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.

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 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/Title (PLEASE PRINT) Date

_____ _____

Employer/Company Name Phone number