Lake Erie Regional Council (LERC)

Working Spouse Eligibility Verification Form

(Must be completed by every Employee who covers a Spouse)

Employee Name:_____ School District: _____

Spouse Name: _____ Phone #:_____

Part 1 To Be Completed By Employee:

My Spouse is (*check one*):

_____ Employed by same district

_____ Self-Employed

_____ Not Employed

_____ Retired

_____ Disabled

LERC's Working Spouse Rule does not apply to items above. If your Spouse meets one of these items, please sign the bottom of this page and return it as required. Part 2 is not required.

OR

_____ Employed Elsewhere
Spouse's Employer must complete Part 2.
Please note that your Spouse will not be covered under the Plan unless Part 2 is completed.

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By signing this attestation, I certify the accuracy of the above information. I understand that if my Spouse is eligible for health care coverage as an employee through his/her Employer, Business or Organization AND if my Spouse's Employer, Business, or Organization does not complete Part 2, my Spouse will not be eligible for secondary coverage under the Plan.

Employee Signature: _____ Date: ____/____/____

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Please return this form to Clearview Local School District with a postmark date no later December 1, 2014 at the address or email address noted below. If your Spouse is employed elsewhere, you must have his/her Employer, Business or Organization complete the information in Part 2 on the other side of this form.

Mail to: Clearview Local School District
4700 Broadway Avenue
Lorain, OH 44052
Phone number: (440) 233-5412
Fax number: (440) 233-6034

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Employee Name:_____ School District:_____

Spouse Name: _____ Phone #:_____

Part 2 To be Completed by Spouse's Employer, Business or Organization

[Name of District] has a plan provision that requires Working Spouses to enroll as an employee in their Employer's, business' or organization's medical plan if the monthly contribution for single coverage under the lowest cost plan is no more than 25% of the monthly premium cost.

To help us verify whether the [Name of District] Employee will be subject to Working Spouse Rule, please complete the information below about your employee and return it to him/her accordingly.

1. Do you offer health care coverage to employees? Yes No
   (If no, please skip question 2 and sign bottom of the form)
2. Is the employee eligible for health care coverage? Yes No

   If eligible, is employee currently enrolled? Yes No

   If NOT eligible, please provide reason:

   ____ Part-time

   ____ Must complete waiting period

   ____ Other (*please indicate below*):

   _____
3. Total monthly plan cost for lowest cost medical/drug plan: $_____
4. Employer portion: $_____
5. Employee portion: $_____
6. Employee contribution %: _____%

Spouse Name: _____

Address: _____

City: _____ State :_____ Zip: _____ Phone Number: (___)_____

Company Benefits Representative Signature: _____

Date: ___/___/___