Akron Public Schools

AKRON PUBLIC SCHOOLS
SPOUSAL COORDINATION OF BENEFITS VERIFICATION FORM

The "Spousal Coordination of Benefits Process" involves determining if your spouse is eligible for other group health benefits and the percentage of the monthly premium that your spouse is required to pay for coverage. This form will be used to validate and determine situations where coordination of benefits is necessary. Please note that a representative of your spouse's employer, if applicable, is required to validate the information that you are providing to Akron Public Schools.

Please submit all completed forms directly to the Benefits Office-70 North Broadway, Akron, Ohio 44308

Section I: Employee Information

Name: _____ Employee ID # _____ SSN# _____

Spouse's Name: _____ SSN# _____ Spouse DOB: ____/____/____

My Spouse is: _____Not Employed _____Employed (FT) _____ Employed (PT) _____ Self Employed _____ Retired

Name of Spouse's Employer: _____

1. Does your spouse's employer offer medical insurance to employees: _____ Yes _____ No	**If no, skip to Signature/Authorization**
2. Is your spouse eligible for group medical benefits? _____ Yes _____ No	**If no, skip to Signature/Authorization**
3. Is your spouse currently enrolled in medical insurance benefits offered by his/her employer _____ Yes _____ No	
4. Is your spouse required to pay less than 15% of the monthly premium cost for medical coverage? _____ YES _____ NO Please indicate the _____% percentage paid by the employee.	

Section II: Signature/Authorization--EMPLOYEE

I certify that that the information provided above is accurate and true to the best of my knoweldge. In order to validate information, Akron Public Schools may conduct audits and/or contact the employer listed. It is fraudulent to fill out this form with any information that is known to be false and/or to omit facts. Providing false information may result in disciplinary action and/or denial of covered benefits. I understand that it is MY responsibility to notify the Benefits Office within 31 days should any of the information provided on this form change.

_____ _____

Employee Signature Date

Section III: Signature/Authorization--EMPLOYER

The information as provided in Section I is true and accurate.

_____ _____

Name and Title of Employer Representative-*Please PRINT* Date

_____

Signature

BENEFITS OFFICE USE ONLY:

Date Formed Received:

Coordination Applies _____ Y _____N Date Additional Forms Sent: _____/_____/_____