Spousal Enrollment Worksheet 2016-2017

Employee will complete this worksheet to determine whether spouse meets the criteria to enroll in the Butler Health Plan for primary medical coverage.

Complete this worksheet:

- *If spouse is currently employed at another Butler Health Plan member district.*
- *If spouse is not eligible for an employer-sponsored or retiree medical plan and is requesting enrollment in the BHP medical plan.*
- *If spouse is already enrolled in his/her employer-sponsored medical or retiree plan and pays more than 55% of the single premium rate.*

Do not complete this form:

If spouse is already enrolled in his/her employer-sponsored medical or retiree plan.

BHP Member Information (Please print or type)

Last Name	First Name	M.I.	SSN

Employer	Location	Primary Phone

Questionnaire

☐ My spouse is eligible for coverage with the Butler Health Plan through his/her school employer.	*If checked, your spouse is waived from the requirement for as long as the condition applies.*
☐ My spouse is unemployed, self-employed or retired and is not eligible for an employer-sponsored medical plan or retiree medical plan (such as SERS or STRS).	*If checked, your spouse is waived from the requirement for as long as the condition applies.*
☐ My spouse is employed but is not eligible for or is not qualified for an employer-sponsored medical plan.	*If checked, your spouse is waived from the requirement for as long as the condition applies.* *<u>You are required</u> to have your spouse's employer complete the Spousal Employer Verification Form on Page 2 and return to Treasurer or Personnel Office or upload.*
☐ My spouse is eligible for coverage through another employer-sponsored or retiree medical plan, but would have to pay more than 55% of the single premium rate.	*If checked, your spouse is waived from the requirement for as long as the condition applies.* *<u>You are required</u> to have your spouse's employer complete the Spousal Employer Verification Form on Page 2 and return to Treasurer or Personnel Office or upload.*

Signature Requirement – Employee and Spouse Acknowledgement of Responsibility:

I understand that spouses of BHP members are required to join their employer's group or retiree health plan (for at least individual coverage) where such availability to coverage exists. I also understand that I must notify the Treasurer or Personal Office and Butler Health Plan if there is a change in my spouse's employment or a change in benefit availability within 31 days of the change. Failure of employee to notify Butler Health Plan of spouse's employment change or falsifying spouse's employment status is fraud and will result in financial penalty and/or loss of coverage for spouse.

Employee Signature:	Date:
Employee's Spouse Signature:	Date:

You may upload this document on the enrollment site <u>https://butlerhealthplan.benelogic.com</u>
or return to your Treasurer or Personnel Office.

Spousal Employer Verification Form 2016-2017

Butler Health Plan requires spouses of covered employees to join their employer's group or retiree health plan, for at least individual coverage, where such availability to coverage exists. In order for your employee to be considered for medical coverage with Butler Health Plan, this form must be completed and returned by the employee.

To be completed by BHP Member	
BHP Member Name:	SSN:
Spouse Name (Your Employee):	SSN:

To be Completed by Spouse's Employer		
☐	My employee **is** eligible for medical coverage through our organization?	*If checked, this employee must enroll for primary coverage through our employer-sponsored medical plan, for at least individual coverage, in order to be eligible for secondary coverage under the Butler Health Plan.*
☐	My employee **is not** eligible for medical coverage through our organization? Reason not eligible: _____	*If checked, this employee is waived from the Butler Health Plan requirement for as long as the condition applies and is eligible to enroll in the BHP medical plan.*
☐	My employee is eligible for our employer-sponsored medical plan and would have to pay more than 55 percent of the total premium rate for their individual medical coverage?	*If checked, this employee is waived from the Butler Health Plan requirement for as long as the condition applies and is eligible to enroll in the BHP medical plan. * Employer please complete the top part of the next section.*

Employer Information *		
Company Name		Phone
Company Address		Date
Company Representative		

Other Insurance Information	Medical Carrier	RX Carrier (if different from Medical)
Insurance Company Name		
Insurance Company Address		
Group Policy Number		
Type of Policy		
Effective Date		
Coverage Type	Employee Only ☐ Family ☐	Employee Only ☐ Family ☐

Dependents Covered Under Above Policy	Medical Carrier		RX Carrier (if different from Medical)	
	Yes ☐	No ☐	Yes ☐	No ☐
	Yes ☐	No ☐	Yes ☐	No ☐
	Yes ☐	No ☐	Yes ☐	No ☐
	Yes ☐	No ☐	Yes ☐	No ☐
	Yes ☐	No ☐	Yes ☐	No ☐
	Yes ☐	No ☐	Yes ☐	No ☐

You may upload this document on the enrollment site https://butlerhealthplan.benelogic.com or return to your Treasurer or Personnel Office.