Youngstown State University
Spouse or Same Sex Domestic Partner – Eligibility Certification

EMPLOYEE SECTION: This form is to be completed upon enrollment or changes to enrollment if the employee covers the spouse/domestic partner on the YSU health plan.
EFFECTIVE DATE___________________________________

Employee Name: _______________________________ Banner ID _________________

Spouse Name: ________________________ Spouse's Date of Birth: __________________

My Spouse/Domestic partner is: (please check one.)

____ Not Employed

____ Retired and entitled to Medicare

____ Retired <u>without</u> access to Employer-Sponsored Coverage

____ An employee of Youngstown State University

____ Self-Employed – Sole Proprietor

____ Employed*

____ Self-Employed (not Sole proprietor)*

____ Retired <u>with</u> access to Employer-Sponsored Coverage*

____ Retired with access to OPERS, STRS, or any government union plans that provide access to other health coverage.*

*If you have checked any of these options, have your Spouse's Employer complete Employer Section below.
Form must be returned to the Benefits Office at YSU Tod Hall

I hereby certify that I am legally married or have completed an affidavit for my Same Sex Domestic partner for the above named individual and that the information provided on this certification form is accurate and truthful.

____ ____________________________________

Employee Signature Date

EMPLOYER SECTION: This section is to be completed by the EMPLOYER of the Spouse

Please check Yes or No for each type of coverage listed.	**Medical/Prescription coverage**
1**. Do you offer group insurance to your employees?**	____Yes ____No
2. **Is the spouse of the YSU employee listed above eligible for coverage?** **Number of hours employee works per week ______**	____Yes ____No If no, explain reason:
3. **Is your employee required to pay <u>more than 50%</u> of the monthly premium for single coverage for any of the Medical plans offered to your employees? _____Yes _____No** **Please indicate the ______Percentage and/or $________ monthly contribution paid by employee.**	

EMPLOYER CERTIFICATION & SIGNATURE
I HEREBY CERTIFY THAT THE ABOVE EMPLOYER AND PLAN INFORMATION IS CORRECT

_______________________________________ _______________________________

Employer Signature Date

_______________________________________ ______________________________

Print Name Phone Number

Company Name: ____

Street Address: ____________________________ City/State/Zip: ________________________

Please see reverse side for important information.

Youngstown State University

Spouse or Same Sex Domestic Partner COB Re-Certification
(Spouse: refers to spouse or same-sex domestic partner on this document)

This requirement does not apply to any spouse who works less than 25 hours per week AND that must pay either more than 50% of the monthly single premium required by the spouse's employer or $300 per month, whichever is greater.

As a condition of eligibility for coverage under the University's group medical/prescription drug plan(s) if an employee's spouse is eligible for group medical/prescription drug coverage sponsored, maintained and/or provided by the spouse's current employer, former employer (for retirees) or business for self-employed individuals (other than sole proprietors) (collectively or individually, "Employer Coverage"), the spouse must enroll for at least single coverage in his/her Employer Coverage unless he/she is entitled to Medicare. The use of the word "spouse" also refers to a same-sex domestic partner.

Upon the spouse's enrollment in an Employer Coverage, that coverage will become the primary payer of benefits, and the coverage sponsored by the University will become the secondary payer of benefits according to the primary plan's Coordination of Benefits and participation rules. In the event the spouse is a Medicare beneficiary and Medicare is secondary to the University coverage, and Medicare is primary to the spouse's Employer coverage, the University Coverage will be the primary coverage. These rules are detailed in O.R.C. §§ 3902.11 to 3902.14.

It is the employee's responsibility to advise the University immediately (and not later than 30 days after any change in eligibility) if the employee's spouse becomes eligible to participate in an Employer Coverage. Upon becoming eligible, the employee's spouse must enroll in the Employer Coverage unless he/she is exempt from this requirement in accordance with the exemptions stated above.

Every employee whose spouse participates in the University group medical/prescription insurance coverage shall complete and submit to the Benefits Department, upon request, a written certification verifying whether his/her spouse is eligible for and enrolled in an Employer Coverage. If any employee fails to complete and submit the certification form, such employee's spouse may be removed from the University Coverage.

PLEASE NOTE:

- **If you and your spouse both work for the University, the employee with the higher income will be the primary holder of the benefits for the couple/family**.