Spousal Eligibility Form
Richland County

Who must complete this form? Any employee electing to cover their lawful spouse under the Richland County Health Plan through County Employee Benefit Consortium of Ohio (CEBCO) effective January 1, 2018 or later must complete this form. A spouse will not be eligible or be enrolled in the Richland County Health Plan until this form is completed and returned to: Richland County Auditor.

This form must be completed in full if an employee's lawful spouse is: actively employed and offered medical coverage by his or her employer, or a retiree offered medical coverage from a previous employer.

The lawful spouse will no longer be covered under the Richland County Insurance effective January 1, 2018. The spouse must enroll in their employer Plan as their primary carrier. (Employees and their spouses that both work for Richland County or an agency or that is part of our insurance does not have to complete this form)

It is important to note that this policy will not affect children or spouses who are not employed or do not have access to employer subsidized medical insurance.

Section 1 – to be completed by Richland County Employee

Employee Name & I.D #:_____

Spouse Name & S.S. #:_____

My spouse actively works? ☐ **Yes** ☐ **No***

My spouse is a retiree from a previous employer? ☐ **Yes** ☐ **No***

* If you answered "No" to both of the questions above, please sign, date and return this form.

Name of Spouse's Employer: _____

Address of Spouse's Employer: _____

I solemnly affirm that the information provided above is true, accurate and complete. I understand that if the status of medical coverage for my spouse changes, it is my responsibility to notify the Richland County Auditor, within 31 days of the change. I understand that failure to notify Richland County Auditor of my spouse's employment or retirement change or providing false information is fraud and may result in health coverage cancellation, financial penalty and/or disciplinary action in accordance with the provisions of my health care plan and/or the Richland County policies.

_____ _____

Employee Signature **Date**

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I authorize my employer to release the information requested below, and I have read and understand the statements regarding the Spouse Policy of the Richland County Health Plan.

_____ _____

Spouse Signature **Date**

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Section 2 – to be completed by Spouse's Employer or Retiree's Former Employer

Richland County implemented a "spouse policy" starting January 1, 2016. The spouse policy requires spouses of County employees who have access to medical insurance to accept that insurance as primary.

Is medical coverage available to your employee or retiree? ☐ Yes ☐ No

If no, explain: _____

Please note: "Loss of eligibility" under the Richland County Health Plan group health plan is considered a Qualifying Event under HIPAA. Your employee may qualify as a "special (late enrollee" under your group health plan.

If "No" to question immediately above, what is the earliest date that your employee or retiree will be allowed to join your employer-sponsored health plan? _____

Please provide Name of Insurance Plan, Group #, Address and Phone #: _____

_____

Please provide Name and Title of HR Representative completing this Form

Name and Title: _____

Employer Name: _____

Employer Address: _____

Employer Phone #: _____

_____ _____

Human Resources Representative Signature **Date**

This completed signed form must be submitted to Richland County Auditor, 50 Park Avenue E., Mansfield, OH 44902 within 31 days of date eligible.

Note: For continuing employees, this form must be completed annually during each enrollment period if your spouse is going to continue as primary under the Richland County Health Plan.