The University of Akron

Office of Benefits Administration
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Akron, OH 44325-0602

Phone (330) 972-7090
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2017 Working Spouse – Primary Coverage Certification

Who must complete this form? Employees electing medical or dental coverage for their spouse.

When must this form be completed? **Annually** during each open enrollment period and within 31 days of hire or qualifying event.

Employee Name (print): _____ **Emp Id #:** _____

Spouse Name (print): _____ **Spouse SSN:** _____

Section A - My Spouse is (check one):

☐ Employed Part Time *(Employer MUST complete Section B.)* ☐ Employed Full Time *(Employer MUST complete Section B.)*

☐ Not Employed ☐ Self-Employed ☐ Retired ☐ Full-time UA Employee

☐ I wish to elect **secondary coverage** for my spouse through UA. (Please sign below and return to Benefits Administration with a copy of your spouse's primary insurance card.)

If my spouse's employment or health insurance coverage status changes in the future, I understand that I am responsible for contacting Benefits and completing the appropriate paperwork within 31 days of the change. I certify the above completed information is true and correct to the best of my knowledge and understand that any misstatement constitutes fraud and may result in termination of benefits and/or employment.

Employee Signature _____ *Date* _____

I, as the spouse of an UA employee, authorize the release of the medical and dental plan coverage information set forth in Section B and authorize its use in making application for UA health and dental insurance.

Spouse Signature _____ *Date* _____

Section B – Employer Certification

1. Is the above named spouse eligible for your group health insurance? ☐ Yes ☐ No
2. Is the above named spouse required to pay 50% or less of your total plan premium? ☐ Yes ☐ No
   If yes, the named spouse is *NOT* eligible for primary coverage under UA's health plan and must enroll in your plan.
   If no, the named spouse is eligible for coverage under UA's health plan.
3. If not already enrolled, when will the named spouse's health coverage with you begin? ____/____/____

Printed Name and Title of Individual Completing the Form _____

Employer Name and Address _____

Employer Phone Number and/or Email _____

The above responses are correct to the best of my knowledge.

_____ _____

Signature of Employer Representative Date