

# Spousal Coordination of Benefits Policy Form



State of Delaware

**PLEASE PRINT ALL INFORMATION REQUESTED**

Check Carrier:  Blue Cross  Aetna

YOUR FULL NAME - Last, First, Middle Initial		YOUR HOME PHONE - Include area code	
YOUR SOCIAL SECURITY NUMBER		Are you and your spouse both benefit eligible State of Delaware employees or retirees? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SPOUSE'S FULL NAME - Last, First, Middle Initial	SPOUSE'S SOCIAL SECURITY NUMBER	<input type="checkbox"/> Male <input type="checkbox"/> Female	SPOUSE'S BIRTH DATE / /

**SPOUSE INFORMATION**

My spouse is: <input type="checkbox"/> Not Employed <input type="checkbox"/> Employed Full-time <input type="checkbox"/> Employed Part-time <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired		
NAME AND ADDRESS OF SPOUSE'S EMPLOYER (If spouse is a benefit eligible State of Delaware employee, simply write State of Delaware in this box and sign/date form)		SPOUSE'S EMPLOYER PHONE NUMBER Include Area Code
Does your spouse's employer offer health care insurance to employees? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your spouse enrolled in health care insurance through his or her employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not enrolled, what percentage of the premium of the lowest benefit employee only plan would your spouse be required to pay?*
	Is this a Health Savings Account (HSA) plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the name of your spouse's health insurance carrier?*	What is your spouse's plan policy number? Effective Date:	Annual plan renewal date for your spouse's employer: Month: Day:
Does your spouse's health plan cover prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Your additional comments:	
If you are completing this form due to your spouse's loss of coverage please indicate the termination date of that coverage. Date:		

**AUTHORIZATION**

**Please read carefully the information below before signing. You are responsible for understanding the requirements of the Spousal Coordination of Benefits Policy described here, for providing verification as requested, and for the accuracy of the information in this form.**

I understand that the following policy applies to spouses who regularly work full-time and are eligible for health coverage through their own employers:

- This information will be shared with the State of Delaware's plan administrator(s).
- If spouses do not enroll in their own employer's health coverage, the State will reduce payment to 20% of covered services provided by the employee's State of Delaware benefit plan, and amounts not paid will be the responsibility of the employee and spouse.
- If spouses enroll in their own employer's health coverage, those plans pay their benefits first. Then the State of Delaware will pay additional covered expenses, if any, up to the maximum allowed under our employee's family benefit plan, not exceeding a limit of 100% coverage from both plans combined.

I understand this form must be completed in order to cover my spouse on my State of Delaware Group Health Insurance Plan. The form is used to determine a spouse's eligibility to receive primary State of Delaware health benefits. Generally, the following spouses are not required to enroll in their company health benefits and may receive primary State of Delaware health benefits:

- Spouses not working full time, or
- Spouses whose employer does not offer health coverage (verification from employer may be required), or
- Spouses who do not yet qualify for coverage through the employer (verification of eligibility date may be required), or
- Spouses whose employers require a contribution of more than 50% of the premium for the lowest benefit employee only plan available (verification from employer may be required).

If any of this information changes, I must complete a new form within 30 days.

**Notice to all parties completing this form:** To insure benefits are coordinated properly between employers, the State of Delaware will verify the accuracy of information by conducting audits, contacting you, and contacting your spouse's employer. It is fraudulent to fill out this form with any information which is false or incorrect or to omit important facts. Providing false or incorrect information may result in disciplinary action and sanctioned payment (reduced to 20%) of claims for your spouse. Any claims paid based on false or incorrect information will be reversed and payment will be the responsibility of the employee.

**Please return the completed form to your organization's Human Resources or Benefits Representative.**

**I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT**

Employee's Signature

Date: / /