Bradford EVSD Spousal Coordination of Benefits Policy Form

This Section to be Completed by all Employees of the Bradford Exempted Village Schools

You are responsible for ensuring the completion and return of this form to the Treasurer's Office. If this form is not received by November 10th of the current year, your enrollment record will automatically indicate your spouse has other coverage and their claims will be suspended until receipt of primary carrier's Explanation of Benefits is received.

Please check the appropriate insurance coverage you currently have with Bradford Schools:

- ❑ Single Coverage Only
- ❑ Employee + Kids Coverage Only
- ❑ Spouse is not Employed
- ❑ No insurance w/BEVSD

- ❑ Family Coverage (IF CHECKED, PLEASE COMPLETE SPOUSE EMPLOYER SECTIONS)

Employee's Name: _____ Date: _____

This Section to be Completed and Signed by Employee's Spouse who elected Family Coverage

Spouse's Name: _____ SSN: _____
(LAST 4 DIGITS ONLY)

I authorize my employer_____ located at _____
to release to the Bradford Exempted Village Schools the information requested on this form.

Spouse's Signature: _____date_____

This Section to be Completed By Spouse's Employer **(BEVSD Dental and Vision insurance is provided at employees cost)**

Dear Employer of a Spouse who is working in the Bradford School District:

The Bradford Exempted Village Schools (BEVSD) Health Benefit Plan requires that a determination be made concerning the eligibility of a spouse for coverage who has at least 50% of the premium cost paid by the employer. The information you provide below will help us make this determination. We appreciate your time and assistance in this matter.

Bradford has adopted a Spousal Coordination of Benefits agreement which requires an employed spouse of an employee of the BEVSD to enroll for single coverage in the medical plans offered by or through contributions from their employer. If a spouse is eligible for coverage through their employer and chooses not to enroll, he or she is not eligible to enroll in the BEVSD Health Benefit Plan.

Please complete the following applicable information on your employee:

Types of coverage and date coverage began or will begin:

☐ Medical Single (___/___ /____) Insurance Co: _____Policy#: _____

☐ Medical Family (___/___ /____) Insurance Co: _____Policy#: _____

☐ We offer medical insurance but this employee is not eligible to enroll because _____

_____

We DO NOT offer: ☐ Medical Insurance ☐ Dental Insurance ☐ Vision Insurance

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Employer Name: _____

Signature of Company Benefits Representative: _____

Phone: _____ Date: _____

* *Please attach any other pertinent information to this form.*

Employer - Please fax this form to Carla G. Surber, CPA, CGMA, BEVSD, at 937.448.2493
If you have any questions, please call 937-448-2770.