YOUNGSTOWN STATE UNIVERSITY

Office of Human Resources 1 Tressel Way, Youngstown, OH 44555

Coordination of Benefits for Medical Coverage

YSU Employee Name: _____ Employee ID: _____

Spouse Name (PRINT): _____

*As a condition of enrollment, this form must be completed if an employee's spouse is enrolling in **medical coverage**.

*This form must be completed annually, within 30 days of a qualifying event, and regardless of primary/secondary coverage.

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

Part A: Spouse

MY SPOUSE IS: *(Check all that apply)*

☐Employed Full-Time ☐Employed Part-Time ☐Not Employed ☐Self Employed

☐Retired ☐Full-Time YSU Employee ☐Part-Time YSU Employee

You must select if your spouse is enrolled in primary or secondary coverage in a YSU medical plan:

☐ I am enrolling my spouse as ***secondary coverage*** on YSU's Medical Plan

☐ I am enrolling my spouse as ***primary coverage*** on YSU's Medical Plan

I understand that if my spouse's medical coverage status changes in the future, it is my responsibility to notify the YSU Benefits Office within 30 days of the event and submit the necessary paperwork to make the change in status. I hereby certify that I am legally married to the above-mentioned individual and that the information provided on this certification form is accurate and truthful.

Employee Signature: _____ Date: _____

* Part B: Employer Information - Required for Enrollment of Spouse in Primary Coverage ONLY

Part B does not apply to spouses who are not employed, self-employed, retired or a YSU employee.
(Must be completed by a Representative of the Spouse's Employer)

1. How many hours per week does this employee work for your organization? _____
2. What is the cost per month for group medical coverage for ***SINGLE ONLY*** coverage? _____
3. What is the percentage of the monthly premium for single coverage? _____
4. Is this employee eligible to enroll in the company's group medical plan? ☐Yes ☐No
5. Is this employee enrolled in the company's group medical plan? ☐Yes ☐No If yes, effective date _____

I HEREBY CERTIFY THAT THE ABOVE EMPLOYER INFORMATION IS CORRECT

Printed Name and Title of Individual Completing the Form: _____

Employer Signature: _____

Employer Name, Phone Number, and/or Email: _____

Return Completed Form To: benefits@ysu.edu or SECURE FAX 330.941.3716