Office of Benefits Administration Phone (330) 972-7090 ASB – 185 E. Mill St. Fax (330) 972-2336

Akron, OH 44325-0602 Email [benefits@uakron.edu](mailto:benefits@uakron.edu)

**2020 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 medical 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 primary 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