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MCSIG
Monterey County Schools Insurance Group

Spouse Primary Coverage Form

(Includes domestic partners)

PLAN YEAR 2010

Who must complete this form? Any employee electing to cover their spouse in a MCSIG PPO plan. Continuing employees will be required to complete/return this form annually if your spouse is going to continue as a dependent on your MCSIG PPO plan.

MCSIG participant name (printed): _____ **SSN# (last 4 digits)** _____

MCSIG participant district: _____

Please check the one box that qualifies your spouse as eligible for coverage as a dependent on MCSIG:

☐ 1. My spouse is unemployed, self-employed, retired or a MCSIG participant (employee of a MCSIG member district).

☐ 2. My spouse is employed and my spouse's employer does NOT offer medical coverage for my spouse.

3. My spouse is employed, my spouse's employer DOES offer medical insurance for my spouse and:

- ☐ my spouse does not meet their employer's medical insurance eligibility requirements; or
- ☐ my spouse's employer pays less than 75% of the employee-only medical premium; or
- ☐ my spouse's employer pays at least 75% of the employee-only medical premium and my spouse is currently enrolled in their employer's medical insurance

AFFIDAVIT: I understand that my spouse must meet one of the eligibility requirements above to quality for enrollment as my dependent in MCSIG. I certify the above information to be true and correct.

Employee's Signature: _____

If box 2 or any box under 3 above is checked, have the spouse sign below and take this form to their employer to complete the spouse employer verification of coverage (below) before returning this form to MCSIG.

I authorize the release of the health care plan coverage information requested below and authorize its use in applying for dependent coverage in MCSIG.

Spouse name (printed): _____

Spouse Signature: _____ **Date:** _____

SPOUSE EMPLOYER VERIFICATION OF COVERAGE

The person named above (spouse) is employed by us and:

- ☐ we do not offer employee medical insurance coverage.

We offer employee medical insurance coverage and:

- ☐ the person named above does not meet our medical insurance eligibility requirements; or
- ☐ we pay less than 75% of the employee-only medical premium; or
- ☐ we pay at least 75% of the employee-only medical premium and the person named above is currently enrolled in our medical insurance coverage.

Authorized Employer Contact Signature: _____

Printed Name and Title: _____

Benefits Department Phone Number: _____

Employer Name: _____

Please return this form to: MCSIG, 76 Stephanie Drive, Salinas, CA 93901, 831-755-0161

Created: August 2009