YOUNGSTOWN STATE UNIVERSITY

One University Plaza, Youngstown, Ohio 44555

Office of Human Resources

Youngstown State University
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 in enrolling in medical coverage.

*This form must be completed annually or within 30 days of a qualifying event.

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 ($500 for faculty), whichever is greater.

Part A: Spouse Information

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

☐ Not Employed ☐ Self Employed ☐ Retired ☐ Employed Full-time ☐ Employed Part-time

☐ Full-time YSU Employee ☐ Part-time YSU Employee

☐ 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 ***(Spouse's Employer must complete Part B)***

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 31 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 named 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

(Must be completed by a Representative of the Spouse's Employer)

1. Is the above named spouse eligible for medical coverage? ☐ Yes ☐ No

2. How many hours per week does your employee work? _____

3. Is your employee required to pay 50% or more of the monthly premium for single coverage for any medical plans offered to an employee? ☐ Yes ☐ No

4. Indicate the percentage _____ and MONTHLY contribution paid by the employee for Single Coverage _____

I HEREBY CERTIFY THAT THE ABOVE EMPLOYER INFORMATION IS CORRECT.

Employer Signature _____

Printed Name and Title of Individual Completing the Form _____

Employer Name and Address _____

Employer Phone Number and/or Email _____