

Employer Certification
Coordination of Spousal Benefits
Fax form to 513 -529-4223

Section A: Miami Employee

Please complete this section before submitting to your spouse's employer.

Miami Employee Name (print) _____ Banner ID _____

Employee Signature _____ Date _____

Spouse Name (print) _____ Spouse SSN _____

Spouse Signature _____ Date _____

Section B: Employer Section (or Group Retiree Health Plan Administrator)

Please answer the following questions regarding the above-named spouse of the Miami employee.

1. Do you offer group health insurance? %oYes %dNo

If no, the named spouse is eligible for coverage under Miami's health plan. Skip questions #2-5.

2. Is this employee eligible for your group coverage? %oYes %dNo

If no, the named spouse is eligible for coverage under Miami's health plan. Skip questions #3-5.

3. If eligible for your group coverage, is the employee required to pay more than 50% of your total plan premium for single coverage? %oYes %dNo

If yes, this employee is eligible for coverage under Miami's health plan. Skip questions #4-5.

If no, this employee is not eligible for coverage under Miami's health plan and must enroll in your plan.

4. Is this employee already enrolled in your group coverage? %oYes %dNo

5. If not already enrolled in your health plan, when will this employee's health coverage with you begin? _____/_____/_____
Date

Company Name

Phone Number

A
