



SIDE 1 – BHP MEMBER COMPLETES THIS SIDE FIRST

BUTLER HEALTH PLAN
COB QUESTIONNAIRE

(Documentation of Spouse's Access to Employer Sponsored Medical Coverage)

- **Complete this form** - if your spouse is eligible for the BHP Medical Plan.
- **Do not complete this form** - if your spouse is already enrolled in his/her employer sponsored medical or retiree plan and you noted this information on your most recent enrollment form.

BHP Member _____	SSN _____
District _____	Building _____
Spouse's Name _____	SSN _____

The BHP COB (Coordination of Benefits) requires spouses of covered employees to join their employer's group health plan (on at least an Individual coverage basis) where such availability to coverage exists. Your spouse's claims will not be considered for payment until this form is completed and returned.

Certain conditions will allow your spouse to be waived from this requirement.

Please Check Appropriate Box (All questions must be answered):

<input type="checkbox"/> Y <input type="checkbox"/> N	My spouse is self-employed and has access to health coverage but must pay 51% or more of the premium cost for Individual coverage.
<input type="checkbox"/> Y <input type="checkbox"/> N	My spouse is self-employed and does not currently have access to a <u>group</u> medical plan.
<input type="checkbox"/> Y <input type="checkbox"/> N	My spouse works part time. (Part-time is defined as <u>LESS</u> than 20 hours a week on average or on a seasonal basis.)
<input type="checkbox"/> Y <input type="checkbox"/> N	My spouse has access to the BHP plan through his/her school employer.
<input type="checkbox"/> Y <input type="checkbox"/> N	My spouse is <u>NOT</u> employed.
<input type="checkbox"/> Y <input type="checkbox"/> N	My spouse is retired and is not actively employed.

- **If you answered "No" to all the above questions**, your Spouse's employer must complete side 2 of this questionnaire. Employee **must** read and sign the box below.
- **If you answered "Yes" to any of the above questions**, your spouse is waived from COB requirement for as long as the condition applies. Read and sign the box below and send this form directly to Allied Benefit Systems. (See mailing address on side 2) or attach to your enrollment form.

SIGNATURE REQUIREMENT – EMPLOYEE ACKNOWLEDGMENT OF COB RESPONSIBILITY:

If my spouse's employment status changes in the future, I understand that I am responsible for completing an Enrollment form and COB Questionnaire within 31 days of the employment status change. Failure to notify my employer of my spouse's employment change or falsifying my spouse's employment status is fraud and will result in financial penalty and/or loss of coverage for my spouse.

Employee Signature _____

Date _____

