# Butler Health Plan

# COB QUESTIONNAIRE - Side 1

*(Do not complete this form if your spouse is enrolled in his/her employer-sponsored medical or retiree plan and you noted this information on your Enrollment Form.)*

The BHP COB (Coordination of Benefits) requires spouses of covered employees to join their employer's group health plan or other group-sponsored plan (for at least Individual coverage) where such availability to coverage exists; however, certain conditions will allow your spouse to be waived from this COB requirement.

BHP Member Name ______________________________ SSN ____________________

School District ______________________________ Building ____________________

Spouse Name ______________________________ SSN ____________________

**FOR EMPLOYEE:**

☐ My spouse has access to the BHP plan through his/her school employer.

☐ My spouse does not have access to an employer-sponsored or retiree medical plan such as SERS or STERS.

**If checked, your spouse is waived from COB requirement for as long as the condition applies. Employee must read and sign the bottom of this form and return to the Allied Benefit Systems.**

**FOR EMPLOYEE:**

☐ My spouse has access to health coverage through another group health insurance plan. This includes retirees with access to group health coverage.

**If checked, you must sign below and your spouse's employer must complete Side 2 of this form and return to Allied Benefit Systems.**

**FOR EMPLOYEE:**

## SIGNATURE REQUIREMENT - EMPLOYEE ACKNOWLEDGMENT OF COB RESPONSIBILITY:

If 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:*** | |
|---|---|---|---|

# COB QUESTIONNAIRE – Side 2

## FOR SPOUSAL EMPLOYER:

The BHP COB (Coordination of Benefits) requires spouses of covered employees to join their employer's group or retiree health plan (for at least Individual coverage) where such availability to coverage exists. In order for primary or secondary medical coverage for your employee to be considered with BHP, you must complete this form and return to Allied Benefit Systems.

☐Y ☐N Does your employee have access to employer-sponsored group or retiree health coverage through employment with your organization?

☐Y ☐N Is your employee required to pay **55 percent or LESS** of the total premium for their Individual medical coverage?

**If "NO" to any of the above**, this confirms your employee is waived from the BHP COB requirement and is eligible for primary coverage through the BHP plan. We require that your organization forward supporting documentation on your company letterhead (i.e. Plan Document, contribution amounts, etc.) with this form to Allied Benefit Systems.

**If "YES" to any of the above**, this requires that your employee (or retiree) must be enrolled for primary coverage through your employer-sponsored health plan on at least an Individual basis in order to remain an eligible dependent for secondary coverage under the BHP plan. Please complete the information below and return to Allied Benefit Systems.

*The above responses are correct to the best of my knowledge.*

| ***Employer Representative:*** | | ***Date:*** | | ***Phone:*** | |
|---|---|---|---|---|---|
| ***Company Name:*** | | | | | |
| ***Address:*** | | | | | |

| | Medical Carrier | RX (if different from Medical) |
|---|---|---|
| ***Name*** | | |
| ***Address 1*** | | |
| ***Address 2*** | | |
| ***Phone Number*** | | |
| ***Policy Number*** | | |
| ***Effective Date*** | | |
| ***Coverage Level*** | ☐Single ☐Family | ☐Single ☐Family |

| Dependents Covered Under Above Policy | Medical | RX |
|---|---|---|
| | ☐Yes ☐No | ☐Yes ☐No |
| | ☐Yes ☐No | ☐Yes ☐No |
| | ☐Yes ☐No | ☐Yes ☐No |
| | ☐Yes ☐No | ☐Yes ☐No |
| | ☐Yes ☐No | ☐Yes ☐No |
| | ☐Yes ☐No | ☐Yes ☐No |
| | ☐Yes ☐No | ☐Yes ☐No |

**Return form and direct inquiries to:**

**Allied Benefit Systems, Inc.**
**Attn: Eligibility Department**
**P.O. Box 909786-60690**
**Chicago, IL 60690**
**Phone: 1-800-288-2078 / Fax: 1-312-906-8879**