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? ❑ Yes ❑ No
   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? ❑ Yes ❑ No
   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? ❑ Yes ❑ No
   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? ❑ Yes ❑ No

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

____ Company Name

_______________________________ Phone Number

____________________________________ Address

__________________________ City

_________ State

_____________ Zip

____ Employer Representative (Please Print)

______________________________________ Title

____ Representative Signature

________/________/___________ Date

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