

Youngstown State University (YSU)
Spouse/Same-Sex Domestic Partner COB Annual Eligibility Certification
 (To be completed by the YSU Employee/Plan Participant – PLEASE PRINT)

1. YSU EMPLOYEE/PLAN PARTICIPANT INFORMATION		
FULL NAME	DATE OF BIRTH	EMPLOYEE SS NUMBER

2. SPOUSE/SAME-SEX DOMESTIC PARTNER INFORMATION <input type="checkbox"/> I am not married (if you are not married, check this box, sign and return). <input type="checkbox"/> I am not married but have a same-sex domestic partner. <input type="checkbox"/> I am married, but my spouse has health and/or prescription drug insurance coverage elsewhere and does not have either coverage under my plan. <input type="checkbox"/> I am married and my spouse has health and/or prescription drug insurance coverage under my plan.
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SPOUSE/ SAME-SEX DOMESTIC PARTNER FULL NAME	DATE OF BIRTH	

Spouse/Same-Sex Domestic Partner is: Not Employed, not Self-Employed, nor Retired Employed or Self-Employed
 Retired on _____ (date) from _____ Other _____
 is: _____ (employer name) Enrolled in Medicare
 Other YSU Employee

If spouse/same-sex domestic partner is NOT EMPLOYED, NOT SELF-EMPLOYED, NOR RETIRED OR ON MEDICARE, STOP, sign below and return form. Otherwise, complete the front side of this form. Have your spouse's employer, self-employer, former employer or retirement plan/system complete the second page of this form.

Is group medical and/or prescription drug insurance available to your spouse/same-sex domestic partner through his/her employer (whether as a current employee, self-employed individual (other than a sole proprietor) in a business (e.g., partner), or a retiree? YES NO

Regardless of your answer:
If your spouse/same-sex domestic partner is employed, your spouse/same-sex domestic partner must have his/her employer, or your spouse/same-sex domestic partner, if self-employed, complete the Employer Information on the second page of this form.

If your spouse/same-sex domestic partner is retired, (1) have your spouse's/same-sex domestic partner's former employer or retirement plan/system complete the back of this form, (2) be sure you provided his/her retirement date and the employer from which he/she retired in the space above, sign and date the bottom of this page.

Youngstown State University (YSU) requires that if your spouse/same-sex domestic partner is eligible to participate in group medical and/or prescription drug insurance sponsored by his/her employer, business, or employer's retirement plan, your spouse/same-sex domestic partner must enroll for at least single coverage in such employer-sponsored group insurance coverage(s). Effective January 1, 2012, any spouse/same-sex domestic spouse who fails to enroll in any medical and/or prescription drug insurance coverage sponsored by his/her employer, business, or employer's retirement plan as required by YSU shall be ineligible for such coverage under the Plan (defined below).

Youngstown State University (the "Plan") provides health and prescription drug insurance benefits. Please be aware that the Plan will rely upon the information contained in this Certification in making its determination regarding your spouse's/same-sex domestic partner's eligibility to receive benefits from the Plan.

Please note that it is your responsibility to advise the Plan via the YSU Human Resources immediately (and not later than 30 days after any change in eligibility), if the employee's spouse/same-sex domestic partner becomes eligible to participate in group medical and/or prescription drug insurance sponsored by his/her employer, business, or employer's retirement plan after the date you submit this Certification. Upon becoming eligible your spouse/same-sex domestic partner must enroll in any group medical and/or prescription drug insurance sponsored by his/her employer, business, or employer's retirement plan and upon such enrollment by the employee's spouse, the Plan will become the secondary payor of benefits.

If the employee or the employee's spouse/same-sex domestic partner submits false information or fails to advise the Plan via YSU Human Resources of a change in the eligibility of the employee's spouse/same-sex domestic partner for group medical and/or prescription drug insurance sponsored by his/her employer, business or employer's retirement plan within 30 days of notification of such eligibility, and such false information or such failure results in YSU providing medical and/or prescription drug insurance benefits to which your spouse/same-sex domestic partner is not entitled, the employee will be personally liable to the University for reimbursement of benefits and expenses, including attorneys' fees and costs, incurred by the University. In addition, the employee's spouse/same-sex domestic partner will be terminated immediately from group medical and/or prescription drug insurance sponsored by YSU. If the employee submits false information in this context, the employee may be subject to disciplinary action by YSU, up to and including termination of employment.

Check if your spouse/same-sex domestic partner is eligible to remain on the Plan with secondary coverage:
 Yes, I certify that my spouse/same-sex domestic partner has enrolled with his/her employer, business or organization (if self-employed), or retirement plan for health insurance and/or prescription drug insurance (effective _____), as detailed on page 2 of this form, and is therefore entitled to remain on the Plan with secondary coverage. Please attach a copy of spouses'/same-sex domestic partners' plan I.D. card or other documentation verifying enrollment in his/her employer's plan or other plan.

3. YSU EMPLOYEE/PLAN PARTICIPANT CERTIFICATION	
I HEREBY CERTIFY THAT I AM NOT MARRIED, or I AM LEGALLY MARRIED TO THE ABOVE NAMED SPOUSE or I AM IN A SAME-SEX DOMESTIC PARTNER RELATIONSHIP as defined by YSU, AND THAT THE INFORMATION PROVIDED IS CORRECT, and understand that, to ensure benefits are coordinated properly between employers, the Plan will verify the accuracy of information by conducting audits, contacting me, and contacting my spouse's/domestic partner's employer.	
X	
EMPLOYEE/PLAN PARTICIPANT'S SIGNATURE & DATE (Required)	AREA CODE / PHONE NO.

4. YSU EMPLOYEE/PLAN PARTICIPANT INFORMATION	
YSU EMPLOYEE FULL NAME	DATE OF BIRTH
COMPANY NAME	GROUP NUMBER
Youngstown State University	390078

YSU SPOUSE'S/SAME-SEX DOMESTIC PARTNER EMPLOYER OR RETIREMENT PLAN CERTIFICATION

Sections 5 through 8 must be completed by the employer/self-employer/former employer/retirement plan/system of the spouse/same-sex domestic partner of the YSU employee. Please be advised that your employee and/or retiree, who is the spouse/same-sex domestic partner of a YSU employee, will lose medical and/or prescription drug insurance coverage through YSU if he/she fails to enroll in group health insurance and/or prescription drug insurance coverage available to him/her through his/her employer, business or employer's retirement plan.

5. SPOUSE/SAME-SEX DOMESTIC PARTNER'S EMPLOYER AND/OR RETIREMENT PLAN INFORMATION	
SPOUSE'S/SAME-SEX DOMESTIC PARTNER'S FULL NAME	SPOUSE'S/SAME-SEX DOMESTIC PARTNER'S DATE OF BIRTH

SPOUSE'S/SAME-SEX DOMESTIC PARTNER'S EMPLOYER'S NAME AND/OR RETIREMENT PLAN NAME: _____

MAILING ADDRESS _____

Do you offer group medical and/or prescription drug insurance (including, but not limited to, insurance requiring employee premium contributions) to:
 (a) employees? YES NO (b) owners/partners? YES NO (c) retirees? YES NO

What is the minimum number of hours required for an employee/owner to participate (regardless of the amount of contribution required)? _____

What type(s) of plans do you offer: Traditional, PPO or POS HMO HRA HSA Qualified HDHP

Is this employee/retiree eligible to participate? YES NO If no, explain why and skip to and complete Section 8 below.

If this employee is not eligible to participate due to number of hours worked, please indicate number of hours this employee works _____

6. HEALTH INSURANCE PLAN INFORMATION

PLAN TYPE: Traditional, PPO or POS HMO HRA HSA Qualified HDHP

INSURANCE COMPANY/TPA NAME: _____

Effective Date of this employee's and/or retiree's Health Insurance Coverage? _____

When was this employee and/or retiree first eligible for Health Insurance Coverage? _____

SINGLE COVERAGE COST ONLY:

MONTHLY EMPLOYER COST \$ _____; MONTHLY EMPLOYEE/RETIREE COST \$ _____ OR _____%

7. PRESCRIPTION DRUG PLAN INFORMATION

Do you have coverage for prescription drugs? Yes No If Yes, please complete the following information.

PRESCRIPTION DRUG INSURANCE COMPANY/PBM NAME : _____

Effective Date of this employee's and/or retiree's Prescription Drug Insurance Coverage? _____

When was this employee and/or retiree first eligible for Prescription Drug Insurance Coverage? _____

SINGLE COVERAGE COST ONLY:

MONTHLY EMPLOYER COST \$ _____; MONTHLY EMPLOYEE/RETIREE COST \$ _____ OR _____%

8. EMPLOYER CERTIFICATION

I HEREBY CERTIFY THAT THE ABOVE EMPLOYER AND PLAN INFORMATION (SECTIONS 5-7) IS CORRECT.

X	SPOUSE'S/DOMESTIC PARTNER'S EMPLOYER SIGNATURE (OR RETIREMENT PLAN/SYSTEM REPRESENTATIVE)	AREA CODE/PHONE
	PRINTED NAME & TITLE	DATE COMPLETED

ATTENTION EMPLOYER: Please return this completed and certified form to your employee.

ATTENTION: YOUNGSTOWN STATE UNIVERSITY EMPLOYEE/PLAN PARTICIPANT: Please return this completed certification form to the Human Resources/Benefits office.