

**ST. CHARLES COMMUNITY UNIT SCHOOL DISTRICT 303 \*SPOUSAL INSURANCE INQUIRY FORM**

Please return completed form to Lonnie at the Administration Center

DATE: \_\_\_\_\_

**SUBSCRIBERS NAME:** (Please Print Your Name Here) \_\_\_\_\_

My spouse is not employed/is self-employed/or is employed less than 30 hours per week.

My spouse is employed by CUSD 303. (Married in District)

Signature of Subscriber: \_\_\_\_\_ Date: \_\_\_\_\_

My spouse is employed full-time

**YOUR EMPLOYEES NAME (Spouse):**

**TO BE COMPLETED BY THE ABOVE LISTED DEPENDENT:**

I authorize my employer to release this information on my behalf.

Signature of spouse: \_\_\_\_\_ Date: \_\_\_\_\_

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**TO BE COMPLETED BY THE ABOVE LISTED SPOUSE'S EMPLOYER:**

Dear Employer,

Your cooperation is required to assist in the review of your employee's access to insurance coverage.

**Please check ONE appropriate answer:**

- We offer group medical coverage and this employee is enrolled.
- We do not offer group medical coverage to our employees.
- We offer group medical coverage and this employee was eligible but did not enroll.
- We offer group medical coverage but this is a new employee who will be eligible on \_\_/\_\_/\_\_.
- We offer group medical coverage but this employee is not eligible because

\_\_\_\_\_  
(Please explain)

**My signature is confirmation that the group benefit plan information I have provided above is true and accurate.**

Signature of employer representative: \_\_\_\_\_ Date: \_\_\_\_\_

Print representative name: \_\_\_\_\_ Title: \_\_\_\_\_

Print employer name: \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Questions? Please call Lonnie at 331-228-4929.

**\*This form will need to be completed ONLY if your spouse is listed on your Medical/Vision benefits.**