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

Please return completed form to Alexia 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: _________________

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 Alexia at 331-228-6769

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