SPOUSE COORDINATION OF BENEFITS FORM

Employee's Statement: To be completed by the covered Employee:

Employer Name: **Wabash City Schools** Group#: **6926**

_____ _____ _____
Name of Employee Member ID# Date of Birth

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Mailing Address: _____ _____ _____ _____
City State Zip Code

Spouse Statement: To be completed by the covered Spouse:

_____ _____ _____
Name of Spouse Social Security # Date of Birth

Spouse's Employer:

_____ _____ _____
Name Address Telephone#

Does spouse's employer provide a group insurance plan: ☐ Yes ☐ No

Is spouse eligible for their employer's group insurance plan: ☐ Yes ☐ No

If yes, does it cost the spouse to be covered: ☐ Yes ☐ No

Does spouse's employer pay 50% or more of cost for spouse: ☐ Yes ☐ No

Type of Plan: Traditional H.S.A HRA (circle one)

List all individuals covered by the spouse's plan: _____

_____

Effective Date of Coverage: _____

Name and address of other insurance company or organization providing benefits or services:

Insurance Company Name:_____ Policy #:_____ Telephone # _____

Street Address:_____City_____State_____Zip _____

SUBMIT COMPLETED FORM TO:
AUTOMATED GROUP ADMINISTRATION, 7605 Westfield Drive, Fort Wayne, IN 46825

I declare that all statements on this form are complete and true and I understand that they are the basis on which benefits are made available under the plan.

_____ _____
Date Employee Signature

_____ _____
Date Spouse Signature