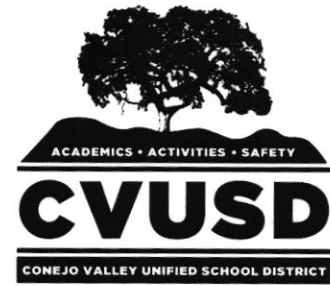


Mark W. McLaughlin, Ed.D
Superintendent

Robert Iezza
Deputy Superintendent
Human Resources



CONEJO VALLEY UNIFIED SCHOOL DISTRICT (CVUSD)

SPOUSE/REGISTERED DOMESTIC PARTNER MEDICAL BENEFIT VERIFICATION

Please read this information carefully. This information only pertains to medical coverage (not dental or vision).

If a spouse or registered domestic partner can obtain health insurance from their employer for any medical plan offered that has an out of pocket cost of \$400 or less, they must enroll in that plan as primary coverage. A spouse or registered domestic partner may enroll in the CVUSD plan as secondary coverage for a cost of:

- Kaiser Permanente - \$125 per month
- Anthem Blue Cross - \$250 per month

Please note: HMO and PPO plans will vary in the coordination of billing primary versus secondary. It is the employee's responsibility to contact their medical carriers regarding primary and secondary billing to find out if there is a coordination of benefits between a spouse's or registered domestic partner's primary medical plan and a CVUSD secondary medical plan.

Please visit the District website <http://www.conejousd.org/Departments/Human-Resources/Employee-Health-Benefits> for benefits information.

Return the form to:

Elizabeth Grigsby
Benefits Technician
(805) 497-9511 x473
egrigsby@conejousd.org



Conejo Valley Unified School District
1400 E. Janss Road, Thousand Oaks, California 91362-2198
Telephone (805) 497-9511 • FAX (805) 449-2631

SPOUSE / REGISTERED DOMESTIC PARTNER MEDICAL COVERAGE ELIGIBILITY VERIFICATION FORM
Return to CVUSD Health Benefits Office

Employee Name: _____

Spouse/Registered Domestic Partner Name: _____

Spouse Employer/Business Name (if employed): _____

Address: _____

Employer's Benefits Representative Name: _____

Employer's Contact Information (phone/email): _____

Please read options below carefully, and check which option is applicable to your Spouse/Domestic Partner:

Table with 4 rows of options for medical coverage eligibility verification, each with a checkbox and descriptive text.

1 Submit medical plan cost information for all medical plans offered by the spouse's/domestic partner's employer. If your spouse/domestic partner receives an allowance for medical coverage, that allowance must be deducted from the out-of-pocket employee only medical expense.

2 A letter from the employer, on company letterhead, stating that no coverage is available must be submitted with this form.

EMPLOYEE'S CERTIFICATION OF SPOUSE/DOMESTIC PARTNER ELIGIBILITY FOR MEDICAL COVERAGE

I hereby certify that I understand the spouse/domestic partner eligibility requirements for CVUSD medical coverage enrollment. I understand that this form must be completed and submitted with any other required information in order to enroll my spouse/domestic partner on CVUSD's medical plan.

I understand that, to ensure the benefits are implemented properly, CVUSD may verify the accuracy of information by conducting audits, contacting me, my spouse's/domestic partner's employer, and/or insurance plan to gather necessary information.

I declare under penalty of perjury that the provided information is true and correct. I understand that misrepresentation of fact, or falsification of information to procure benefits is an act of fraud against the District.

Signature: _____
Employee

Date: _____

Signature: _____
Spouse/Registered Domestic Partner

Date: _____