Ann N. Bonitatibus Ed.D.
Superintendent

Mark McLaughlin
Assistant 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/BusinessServices/EmployeeHealthBenefits.aspx for benefits information.

Return the form to:

Elizabeth Jacobs
Benefits Technician
(805) 497-9511 x473
ejacobs@conejousd.org

Conejo Valley Unified School District
1400 E. Janss Road, Thousand Oaks, California 91362-2198
Telephone (805) 497-9511 • FAX (805) 497-2581

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 specify which option is applicable to your Spouse/Domestic Partner:

☐	CAN obtain HMO or PPO single-party medical coverage through employer's medical plan at an ***out-of-pocket*** monthly cost of $400 or less; ☐ DO NOT enroll my Spouse/Domestic partner from CVUSD medical coverage. ☐ Enroll my Spouse/Domestic Partner in CVUSD **SECONDARY** medical coverage.
☐	CAN only obtain HMO or PPO single-party medical coverage through employer's medical plan at an ***out-of-pocket*** monthly cost ***greater than $400.*** [1] Enroll my Spouse/Domestic Partner on CVUSD plan as PRIMARY medical coverage
☐	CANNOT obtain either HMO or PPO single-party medical coverage through Spouse/Domestic Partner's employer's medical plan. [2] Enroll my Spouse/Domestic Partner on CVUSD plan as PRIMARY medical coverage
☐	CANNOT obtain medical coverage due to self-employment, unemployment, retirement, etc. Enroll my Spouse/Domestic Partner on CVUSD plan as PRIMARY medical coverage

[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. Incomplete forms and/or forms missing participant's and spouse's/domestic partner's signatures will not be processed. I understand that I must provide notice within 30 days to the Employee Benefits Department, if there is a change to the information provided on this form, including a change in marital status, or spouse health benefit coverage eligibility or cost (new form must be submitted within 30 calendar days).

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. Failure to provide true and correct information, or failure to report a change in spouse/domestic partner enrollment eligibility, may result in termination of the employee's health coverage (as well as any covered dependents), disciplinary action, and financial restitution to the District for paid medical premiums and any medical costs incurred by the District for an ineligible enrollment of a spouse/domestic partner.

Signature: ____________________ Date: __________
Employee

Signature: ____________________ Date: __________
Spouse/Registered Domestic Partner