Employer Certification
Coordination of Spousal Benefits
Fax form to 513 -529-4223

Section A: Miami Employee
Please complete this section before submitting to your spouse's employer.

Miami Employee Name (print) _____ Banner ID _____

Employee Signature _____ Date _____

Spouse Name (print) _____ Spouse SSN _____

Spouse Signature _____ Date _____

Section B: Employer Section (or Group Retiree Health Plan Administrator)

Please answer the following questions regarding the above-named spouse of the Miami employee.

1. Do you offer group health insurance? ‰Yes ‰No
   If no, the named spouse is eligible for coverage under Miami's health plan. Skip questions #2-5.

2. Is this employee eligible for your group coverage? ‰Yes ‰No
   If no, the named spouse is eligible for coverage under Miami's health plan. Skip questions #3-5.

3. If eligible for your group coverage, is the employee required to pay more than 50% of your total plan premium for single coverage? ‰Yes ‰No
   If yes, this employee is eligible for coverage under Miami's health plan. Skip questions #4-5.
   If no, this employee is not eligible for coverage under Miami's health plan and must enroll in your plan.

4. Is this employee already enrolled in your group coverage? ‰Yes ‰No

5. If not already enrolled in your health plan, when will this employee's health coverage with you begin? _____/_____/_____ Date

_____ _____
Company Name Phone Number

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