DOCUMENT REQUIREMENTS FOR MEDICAL/DENTAL/VISION ENROLLMENT

For Spouse:

- A copy of your Marriage Certificate
- AND a copy of spouses Social Security Card
- AND a completed Spousal Carve Out Notice (See attached)
- AND a copy of a document dated within the last 60 days showing current relationship status such as a recurring monthly household bill or statement of account. The document must list your spouse's name, the date and your mailing address.

For Child or Disabled Child

- Copy of child's Social Security Card
- AND a copy of the child's birth certificate or adoption certificate (or hospital birth record) naming you and your spouse as the child's parent, OR
- A copy of the court order naming you or your spouse as the child's legal guardian.

HOOSIER SCHOOL BENEFIT TRUST (HSBT) GROUP BENEFIT PLAN
MSD OF DECATUR TOWNSHIP SCHOOL CORPORATION
SPOUSAL CARVE OUT NOTICE / DEPENDENT VALIDATION

Please read and complete this form. If applicable, please return all supporting documentation with your enrollment form.

HSBT has a spousal carve-out provision in their medical plan. As such, if the spouse of a HSBT health plan participant is employed and eligible for coverage under his/her employer's health plan, that spouse is required to enroll in that plan before being eligible for coverage under the HSBT plan. If additional coverage for the spouse is elected under the HSBT group health plan, the spouse's coverage would be "Primary" (claims considered first) and the HSBT plan would be "Secondary" (claims considered second).

Please note there are certain exceptions that will allow for your spouse to remain on the HSBT group health plan as "primary".

- If your spouse's employer does not offer health coverage.
- If your spouse is employed part-time and is not eligible for health coverage under the employer's plan.
- If your spouse's employer does not pay at least 60% of a single employee's premium.

If you wish to elect coverage for your spouse under the Hoosier School Benefit Trust Group Health Benefit Plan please complete the following information and have it verified by your spouse's employer:

Decatur Township Employee: _____

Spouse name: _____

Is your spouse employed? __Yes __No

If yes, please provide:
Name of Employer: _____
Address of Employer: _____
Phone of Employer: _____
Contact Name: _____

Is medical coverage available? __Yes __No

Is your spouse covered under the plan? __Yes __No

Does your spouse's employer pay less than 60% of a single employee's premium? __Yes __No

Signature of the Employer's contact to verify the coverage information:

_____ Date: _____

I declare that the information I have furnished above, to the best of my knowledge is true, complete and correct. Furthermore, I understand it is my obligation to advise my employer should my spouse become eligible for other coverage. I accept personal responsibility for any claims that might be paid incorrectly because my spouse was eligible for coverage elsewhere.

Signature of Decatur Township Employee: _____ Date: _____