Grove City Area School District

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OFFICE OF THE BUSINESS MANAGER

Kim E. Buchanan, CPA
BUSINESS MANAGER

TO: All District Employees with Medical Coverage

FROM: Kim Buchanan

RE: July 2019 Insurance Changes

DATE: December 14, 2018

Effective July 1, 2019, Grove City Area School District Health Care Benefits will be transitioned to the Allegheny County School Health Insurance Consortium (ACSHIC). Upon transition, the District will utilize the plan in effect through ACSHIC. As part of this upcoming transition, the District must enroll all employees who elect coverage in this plan.

ACSHIC rules require that all members verify the eligibility of their dependents. In order to be fully prepared for this change, I am asking every employee to please complete the enclosed forms for your spouse and/or dependent child(ren). Sign and return the original form with the appropriate documentation. If you do not satisfy the requirements noted, your dependent's coverage will be terminated. All documentation should be received at the business office by **Wednesday, February 28, 2019.**

If you have any questions concerning this change, please do not hesitate to contact The Business Office (724) 458-7993.

We greatly appreciate your cooperation in making this a smooth transition.

Dependent Child(ren) Verification Form

Instructions: Please complete this form for all dependents.

Select only **ONE** form of documentation per dependent and check the applicable box. Attach a copy of the document to this form.

STEP 1: For ALL Dependents		**Child 1**	**Child 2**	**Child 3**
	CHILD'S NAME			
Biological Child	Copy of Birth certificate or birth record showing employee as parent.			
Adopted Child	Copy of Court approved adoption order or placement order; or, modified birth certificate.			
Stepchild	Copy of Birth certificate or birth record showing spouse as parent. If your spouse is not covered under the Employer sponsored plan, you must also submit a **copy of your marriage certificate** along with the child's birth certificate.			
Permanent Legal Guardianship	Copy of Court Documents (see below)			
None of the above	Please attach explanation to this form	☐	☐	☐
Voluntary Removal	I have reviewed the eligibility guidelines and the person noted above is no longer eligible for coverage. By selecting this option, I acknowledge that I understand his or her coverage will be terminated, effective April 1, 2018 and will not be eligible for COBRA continuation coverage.	☐	☐	☐

Court Documents: Qualified Medical Child Support Order (QMCSO); Divorce Decree or National Medical Support Notice (NMSN) or Legal Guardianship.

Documentation must include:

- Name of the employee, spouse, or domestic partner as responsible party
- Name(s) of minor child(ren)
- Health care coverage requirements (QSMCO and NMSN only)
- Judge's signature, support order number, and seal

STEP 2: For Dependents age 26 and older ONLY			
Is your dependent considered totally or permanently disabled?	Y / N	Y / N	Y / N

STEP 3: Signature (This form will only be processed if the EMPLOYEE'S signature is present below.)

I certify the information I have provided is true and correct and that I am responsible for updating this information in the event it changes. I understand the information will be reviewed and a determination will be made regarding my dependent's eligibility for coverage. I acknowledge that falsifying information or failing to update this form can lead to cancellation of my dependent's coverage and disciplinary action up to and including termination of employment. Submission of this form does not guarentee eligibility for benefits.

Employee Signature (Required) **Date**

Please **DO NOT** send originals - they will not be returned. Please **keep a COPY** of this document for your records.

Spouse Verification Form

Instructions: Please complete **ALL STEPS** of this verification form for your spouse. For the purposes of this Form, the person identified in STEP 1 below will be referred to as your "dependent."

STEP 1: Qualification of Marital or Domestic Partnership Status
(Please provide a response for EACH item listed below. Responses left blank will be considered "incomplete.")

Item 1	Please confirm the gender of your dependent (Circle one)	**Male** **Female**
Item 2	My current relationship with the person noted above is: ☐ Legally Married ☐ Legally Divorced ☐ Single (remainder is N/A) ☐ Other (Please explain on the back of this form)	

STEP 2: Proof of Marital Status
(Please select ONE of the following options and attach the REQUIRED documentation. Please provide COPIES ONLY.)

Option 1	**Employee's 2016 or 2017 federal tax return** Tax Return Information: Acceptable tax documentation samples include a federal tax return (1040 form or 1040A form). Please include BOTH page 1 and page 2 of the tax return. Page 2 must include signatures or an e-file confirmation number. "Mark out" all financial information and the first five digits of all Social Security numbers.	
Option 2 (Be certain to include your marriage certificate AND ONE document from Part 2)	**Part 1:** Provide a copy of your marriage certificate	
	Part 2: Select ONE of the following forms of proof of joint ownership: • Copy of a mortgage statement • Copy of a bank statement • Copy of a utility bill or current rental or lease agreement **Documents must be dated on or after 07/01/2017 and show current mailing address, employee's name and spouse's name.** *DO NOT send an envelope as proof of joint ownership.*	☐ ☐ ☐
Option 3	If marriage occurred on or after July 1, 2017, marriage certificate only.	☐
Option 4	If legally divorced, please provide the portions of the court documents confirming the names of both parties; date of the divorce and judge's stamp or signature.	
Option 5	I have reviewed the eligibility guidelines and the person noted above is no longer eligible for coverage. By selecting this option, I ackowledge that I understand his or her coverage will be terminated, effective April 1, 2018 and will no longer be eligible for COBRA continuation coverage.	☐
Option 6	None of the Above (Please see attach documents and explanation to this form.)	

STEP 3: Signature (This form will only be processed if the EMPLOYEE'S signature is present below.)

I certify the information I have provided is true and correct and that I am responsible for updating this information in the event it changes. I understand the information will be reviewed and a determination will be made regarding my dependent's eligibility for coverage. I acknowledge that falsifying information or failing to update this form can lead to cancellation of my dependent's coverage and disciplinary action up to and including termination of employment. Submission of this form does not guarentee eligibility for benefits.

_____ _____

Employee Signature (Required) **Date**

Please DO NOT send originals - they will not be returned. Please keep a COPY of this document for your records.