CORE BENEFITS INC.
Quality, Compliance & Service

Coordination of Benefits Inquiry

Employee Name_____ Group Name_____

Please indicate whether or not the spouse enrolled on this plan is employed. ☐ Yes ☐ No

- Employees who have elected spousal coverage must have this form completed by the spouse's employer (if employed) and returned to the Personnel Department by fax at **(260) 373-1695**.
- If the spouse is not employed, please mark the appropriate box above and return to the Personnel Department.
- Spouses who have access to benefits through their employer must enroll in their employer's benefit plan.
- If this form is not turned in before your eligibility date (or July 1st if during an open enrollment period), your spouse will not be eligible to enroll for benefits.
- The spouse's employer must indicate on this form the availability of coverage or lack thereof.

TO BE COMPLETED BY SPOUSE'S EMPLOYER:

Employee Name: _____ Date of Hire: _____

Do you offer Group Health Coverage? ☐ Yes ☐ No

Is the employee eligible for coverage? ☐ Yes ☐ No If "Yes" eligibility date: _____

Check if applicable: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

If not eligible, indicate why: _____

_____

Is this employee currently covered by an employer – sponsored health care plan? ☐ Yes ☐ No

If not eligible at the present time, will he/she be eligible at a future date? ☐ Yes ☐ No

If yes, please indicate date: _____

_____

Authorized Signature Title Date

Name, Address and Phone Number of Employer

_____

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_____

Name, Address and Phone Number of Plan Administrator/Carrier:

_____

_____

_____

EMPLOYER: Please return this form by fax to (260) 373-1695