Employee Certification

The undersigned employee, who is covered under the Chester County Intermediate Unit's Employee Health Care Plan for medical and prescription coverage (hereinafter the "Plan") certifies as follows:

(a) I am familiar with the restrictions on eligibility of my spouse to participate in the Plan, and under that the IU is relying on the representations contained herein.

(b) My spouse **is eligible** to participate in the Plan because **(check one):**

( ) My spouse is not employed.

( ) My spouse is retired.

( ) My spouse is self-employed and does not have a group policy for him/herself and any staff. *(Complete the SPOUSE'S SELF-EMPLOYMENT CERTIFICATION section on the reverse side.)*

( ) My spouse is also employed by the Chester County Intermediate Unit.

( ) My spouse is employed, but not eligible to participate in the health plan(s) offered by my spouse's employer OR my spouse's employer does not offer a health plan. *(Complete the SPOUSE'S EMPLOYER'S CERTIFICATION section on the reverse side.)*

- If my spouse should become eligible to participate in the health plans(s) offered by my spouse's employer, I acknowledge that I must notify the Chester County Intermediate Unit within thirty (30) days of such event and have his/her participation as a dependent terminated.

( ) My spouse is employed and eligible for participation in the health plan(s) offered by the spouse's employer, but required to pay an amount **25% or greater** of the spouse's employer's monthly premium for such coverage. *(Complete the SPOUSE'S EMPLOYER'S CERTIFICATION section on the reverse side.)*

(c) My spouse **is *not* eligible** to participate in the CCIU Health Care Plan because:

( ) My spouse is employed, eligible for participation in the health plan(s) offered by the spouse's employer, and required to pay ***less than 25%*** of the spouse's employer's monthly premium for such coverage. *(Complete the SPOUSE'S EMPLOYER'S CERTIFICATION section on the reverse side.)*

I acknowledge and agree to indemnify and reimburse the CCIU for any costs, liability, or expenses, including accountant's and attorney's fees, which the IU may incur as a result of permitting my spouse to participate in the Plan based on my certification above, if it is determined that my spouse was not eligible to participate in the Plan.

_____ _____

Date Employee's Signature

_____

Print Name

PLEASE TURN PAGE OVER

Please complete the Spouse's Employer's Certification Section if you checked off the 5th, 6th or 7th option on the reverse side.

Spouse's Employer's Certification

SECTION I

_____ ("Employer") hereby affirms that the IU Employee's spouse,
Print Spouse's Employer's Name

_____ is:
Print Spouse's Name

( ) Eligible to participate in the health plan(s) offered by the employer. *(Stop here and proceed to complete Section II of the form.)*

( ) Not eligible to participate in the health plan (s) offered by the employer OR the employer does not offer healthcare plans *(Sign in the designated space below).*

_____ _____
Spouse's Employer's Signature *Date*

_____ _____
Print Name *Print Title*

_____
Provide the Very First Date of Eligibility

SECTION II

_____is required to pay an amount:
Print Spouse's Name

( ) **25% or greater** of the Employer's monthly premium for such coverage.

( ) **Less than 25%** of the Employer's monthly premium for such coverage.

_____ _____
Employer's Signature *Date*

_____ _____
Print Name *Print Title*

_____
Provide the Very First Date of Eligibility

Please complete the Spouse's Self-employment Certification section if you checked off the 3rd option on the reverse side.

Spouse's Self-Employment Certification

_____ hereby affirms that the IU Employee's spouse,
Print Spouse's Company Name

_____ is self employed and does not offer a health insurance plan for him/herself or
Print Spouse's Name employee(s):

_____ _____
Employer's Signature *Date*

_____ _____
Print Name *Print Title*