VALLEY VIEW SCHOOL DISTRICT 365 U
SPOUSE/CIVIL UNION PARTNER INSURANCE INQUIRY FORM

Please return completed form to the Benefits Department at the Administration Center
801 W. Normantown Rd, Romeoville IL 60446 Fax # 815-886-6386

DATE: _____

VALLEY VIEW EMPLOYEE'S NAME: _____ **EIN:** _____

☐ **My spouse/civil union partner is <u>NOT</u> employed/is self-employed/or is employed less than 30 hours per week.**

☐ **My spouse/civil union partner is employed by VVSD 365U.**

Signature of VVSD Employee: _____ Date: _____

☐ **My spouse/civil union partner is employed <u>full-time-(30 or more hours per week)</u>**

YOUR SPOUSE/CIVIL UNION PARTNER'S NAME: _____

TO BE COMPLETED BY THE ABOVE LISTED DEPENDENT:

I authorize my employer to release this information on my behalf for purposes of determining my eligibility for the Valley View School District Health/Vision plan.

Signature of VVSD employee's spouse/civil union partner: _____ Date: _____

TO BE COMPLETED BY THE ABOVE LISTED SPOUSE/CIVIL UNION PARTNER'S EMPLOYER:

Dear Employer,
Your cooperation is required to assist in the review of your employee's access to insurance coverage.

Please check ONE appropriate answer:

- ☐ We offer group medical coverage and this employee is enrolled.
- ☐ We do not offer group medical coverage to our employees.
- ☐ We offer group medical coverage and this employee was eligible but did not enroll.
- ☐ We offer group medical coverage but this is a new employee who will be eligible on __/__/__.
- ☐ We offer group medical coverage but this employee is not eligible because _____.
  (Please explain)

Signature of employer representative: _____ Date: _____
Print representative name: _____ Title: _____
Print employer name: _____ Business Phone (___)_____
Address _____City_____State___Zip_____

Questions? Please call the Benefits Department at 815-886-2700 ext. 6015.

***This form will need to be completed ONLY if your spouse/civil union partner is listed on your Medical/Vision benefits.**