



SPOUSAL COORDINATION OF BENEFITS SELF SERVICE GUIDE

(STATE OF DELAWARE PENSIONERS, PARTICIPATING GROUP EMPLOYEES, UNIVERSITY OF DELAWARE EMPLOYEES AND COBRA PARTICIPANTS)

Phone: 1-800-489-8933 • Email: benefits@delaware.gov • Website: de.gov/statewidebenefits

This guide provides step-by-step instructions to complete the online Spousal Coordination of Benefits Form for State of Delaware Pensioners, Participating Group Employees, University of Delaware Employees, and COBRA Participants. If you cover your spouse in one of the State of Delaware's Group Health Insurance medical plans, you **MUST** complete the online Spousal Coordination of Benefits (SCOB) Form upon initial enrollment, each year during Open Enrollment and anytime your spouse's employment or insurance status changes. **Failure to submit a new Spousal COB form each year will result in a reduction of spousal benefits.**

To complete the form, you will need:

- Your spouse's full name, birthdate, and Social Security number.
- Name of your spouse's employer or former employer and date of retirement if spouse is retired.
 - **If applicable and spouse is enrolled:** Your spouse's insurance information: carrier name, policy number, and effective date.
 - **If applicable and spouse is not enrolled:** The percentage of the premium of the lowest benefit employee only/retiree only plan your spouse would be required to pay (this includes any payments or credits provided by your spouse's employer toward premiums or purchase of medical coverage).
- Your valid email address (confirmation will be sent once you have successfully completed the form).
- Your State of Delaware Pension ID number (if you are a State of Delaware Pensioner).

Access the Spousal Coordination of Benefits (SCOB) Form through the Statewide Benefits Office Website

Visit de.gov/statewidebenefits and

1. Select your **Group**.

2. Select **Spouse & Dependents**

3. Under the header **Forms**, select **Electronic Form**.

4. **Read This First** for important information section and then open the **Select Group** drop down box at the bottom of the page.

Select your group then select **Next**.

IMPORTANT:

If at any point during the online form process the web browser's navigation is used to **leave a page**, a warning message will appear. By selecting **Leave this Page**, you will leave this site and **ALL** information entered will be **LOST**. The form will **NOT** be completed and will require that you complete a new form.

As you complete this form, only the sections that require a response will be opened up for data entry. All fields marked with a **red (*)** are required **in the format shown** to continue to the next screen. Any grayed out sections do not require a response. If you need to provide additional information please use the "Comments" box on each form.

If you cover a spouse under your Highmark Delaware or Aetna health plan, you are **REQUIRED** to complete a Spousal COB Form online to determine your spouse's eligibility status. The online form must be completed **within 30 days** of enrolling your spouse in a State of Delaware health plan, **within 30 days** of your spouse losing or gaining employee coverage and **every year** during Open Enrollment in May. **Failure to complete a Spousal COB Form or provide documentation when required will result in a reduction of your spouse's coverage.**

Completion or modification of the Spousal COB form alone does NOT enroll and/or terminate your spouse's coverage in your health plan. If your spouse's employment or insurance status changes anytime throughout the year, you must also contact your human resources representative to enroll or terminate your spouse in your health plan.

Please read the acknowledgement sections at the end of this form carefully. You are responsible for understanding the requirements of the Spousal Coordination of Benefits Policy described here, for providing verification as noted, and for the accuracy of the information in this form.

Additional information not covered by the form should be entered into the "Comments" sections at the end of the form. If any information entered on this form is found to be false or incorrect, and medical claims are paid based on the false or incorrect information, the employee will be required to reimburse the State.

As you complete this form, only the sections that require a response will be opened up for data entry. Any grayed out sections do not require a response. If you need to provide additional information please use the Comment box at the end of the form.

Completing the SCOB Form

1. In the **Employee Information** section, select the non-Medicare health plan your Spouse is enrolled in, and fill in **YOUR** information (to identify you as the benefits holder).

IMPORTANT:

State of Delaware Pensioners **MUST** provide your State of Delaware Pension ID number in the appropriate field.

Your Pension Employee ID can be found on your pension pay advice and on the Open Enrollment Packet letter (top right corner) that you received in the mail.

Employee Information

Choose your Carrier (Select the non-Medicare plan your spouse is enrolled in): Aetna Highmark Delaware

First: * M.I. Last: *

Phone: * XXX-XXX-XXXX

Social Security Number: * XXX-XX-XXXX

Date of Birth: * mm-dd-yyyy

Pensioner Employee Id: * XXXXXX

Email Address: * address@example.com

Please ensure email address is typed correctly as this is where email verification will be sent.

Spouse Information

First: * M.I. Last: *

Gender: * Male Female

Social Security Number: * XXX-XX-XXXX

Date of Birth: * mm-dd-yyyy

Are you completing this form due to a change in your spouse's employment or medical coverage (if you are completing this as part of the Annual Benefits Open Enrollment requirement, select "No")? * Yes No

Is Your Spouse Enrolled In Medicare, Medicare Disability or Medicaid? * Yes No

My Spouse Is (Explain this): * **Select Employment**

Continue

2. In the **Spouse Information** section, select your Spouse's Employment Status from the **My Spouse Is** drop down box. The employment option selected will open up the required questions.
3. Select **Continue**.
4. Complete the **Spouse's Employer** or **Spouse's Former Employer Information** section, as applicable. The Employer Name field only accepts letters, numbers and spaces. No special characters (apostrophe, comma, or symbols) can be entered.
5. Select **Continue**.

Gender: *

Social Security Number: *

Date of Birth: *

Are you completing this form due to a change in your spouse's employment or medical coverage (if you are completing this as part of the Annual Benefits Open Enrollment requirement, select "No")? * Yes No

Is Your Spouse Enrolled In Medicare, Medicare Disability or Medicaid? * Yes No

My Spouse Is (Explain this): * **Select Employment**

- Select Employment
- Benefit Eligible State Employee
- Employed Full Time
- Partner/Owner/PartOwner OfCorp
- Self Employed/Sole Proprietor
- Part-Time with Insurance
- Part-Time without Insurance
- Not Employed with Insurance
- Not Employed without Insurance
- Retired and Collecting Pension
- Retired and Not Collecting Pension

Select Employment

Verification and Authorization

- Step 1- Summary** - Review the information in this section to verify your data entry. If all the information is correct, scroll down the page to begin the **authorization process**.

IMPORTANT: If you need to make changes to the information that you entered before beginning the authorization process, use the yellow **Back** button. **DO NOT** use the web browser navigation to return to a page, otherwise **ALL** information will be **LOST**, and your SCOB form will **NOT** be completed.

Selecting the **Cancel Form** button will also delete all of your data entry, and you will need to start over.

2. Steps 2, 3 and 4 - Authorizations

- Please read each authorization.
- Select **Accept and Continue** for Authorizations 1 and 2, and **Accept** for Authorization 3.

Accepting each authorization certifies you have read and understand all information included in the authorization section.

Spousal Coordination of Benefits Form

Please verify your data entries. If you need to make corrections, use the back button to return to the section you need to correct. If your entries are correct, certify below and complete your submission.

If your spouse lost coverage and/or employment as a result of the COVID-19 pandemic, please enter "Change is the result of COVID-19" in the Additional Comments box below.

Additional Comments:

500 characters remaining

Step 1 - Summary

Please review a summary of what you have entered so far.

Submission to Aetna

Employee:

Name: John Doe
 Phone: 3025551234
 SSN: 123456789
 Date of Birth: 12251955
 Employee ID: 000001
 Email Address: john.doe@gmail.com

Spouse:

Name: Jane Doe
 SSN: 123456789
 Date of Birth: 10311954

Spouse Employment/Coverage Change: N
 Spouse Enrolled in Medicare, Medicare Disability or Medicaid:
 Employment Status: Employed Full Time

Spouse Employer Info:

Name: Company A
 Employer Offers Medical Insurance: Y
 Spouse Enrolled in Insurance Plan: Y
 Plan Includes a Health Savings Account (HSA): N
 Employer Offers Prescription Drug Coverage: Y
 Employer Offers Cash In Lieu: N
 New Hire Waiting Period: N

Spouse Insurance Info:

Spouse Carrier: Insurance Company
 Policy Number: 123456789
 Policy Effective Date: 02142023

Back

Step 2 - Authorization 1

I understand that the following policy applies to spouses who regularly work full-time and are eligible for medical coverage through their own employers and spouses who are retired and are eligible for medical coverage through their former employers:

- This information will be shared with the State of Delaware's plan administrator(s).
- If spouses do not enroll in their own employers' (or former employers') medical coverage, when required, the State will reduce payment to 20% of covered services provided by the employee's State of Delaware benefit plan, and amounts not paid will be the sole responsibility of the employee and spouse.
- When spouses of State of Delaware employees or retirees enroll in their employers' (or former employers') coverage, those plans pay benefits first. Then the State of Delaware will pay additional covered expenses, if any, up to the maximum allowed under our employee's medical plan, not exceeding a limit of 100% coverage from both plans combined.
- It is fraudulent to fill out this form with any information which is false or incorrect or to omit important facts. Providing false or incorrect information may result in disciplinary action and sanctioned payment (reduced to 20%) of claims for your spouse. Any claims that paid based on false or incorrect information will be reversed, and payment will be the responsibility of the employee.

Accept and Continue **Cancel Form**

Step 3 - Authorization 2

I understand that the following policy applies to spouses who regularly work full-time and are eligible for medical coverage through their own employers and spouses who are retired and are eligible for medical coverage through their former employers. Generally, the following spouses are not required to enroll in their company medical benefits and may receive primary State of Delaware medical benefits (verification may be required from the spouse's employer):

- Spouses not working full time, or
- Spouses who are self-employed / sole proprietors, or
- Spouses who do not yet qualify for medical coverage through their employer, or
- Spouses whose employers (or former employer, if retired) require a contribution of more than 50% of the premium for the lowest benefit employee-only plan available, or
- Spouses whose employers (or former employer, if retired) do not offer medical coverage, or
- Spouses who (1) retired before October 1, 2011, (2) declined coverage at the time of retirement, and (3) are now not permitted to enroll during the employer's next Open Enrollment.

For additional information, view the complete [Spousal Coordination of Benefits Policy](#)
 It is fraudulent to fill out this form with any information which is false or incorrect or to omit important facts. Providing false or incorrect information may result in disciplinary action and sanctioned payment (reduced to 20%) of claims for your spouse. Any claims that paid based on false or incorrect information will be reversed, and payment will be the responsibility of the employee.

Accept and Continue **Cancel Form**

Step 4 - Authorization 3

If any of this information changes, I must complete a new form within 30 days. In addition, a new form must be completed annually during Open Enrollment.

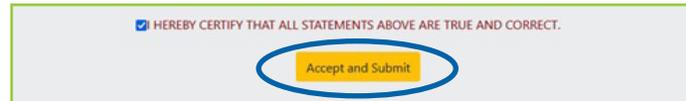
Notice to all Parties Completing this Form

To ensure proper coordination of benefits with other health care coverage, the State of Delaware will verify the accuracy of information by conducting audits, contacting you, and/or contacting your spouse's employer or former employer.

It is fraudulent to fill out this form with any information that is false or incorrect or to omit important facts. **Providing false or incorrect information may result in disciplinary action and sanctioned payment** (reduced to 20%) of claims for your spouse. Any claims that paid based on false or incorrect information will be reversed, and payment will be the responsibility of the employee. Completion of a new form is required if health care coverage or employment changes.

Accept **Cancel Form**

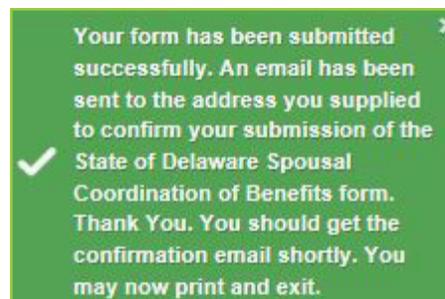
- After accepting all three (3) authorizations, you will be asked to certify all statements by placing a check mark in the boxes on the form. Then click **Accept and Submit**.



HEREBY CERTIFY THAT ALL STATEMENTS ABOVE ARE TRUE AND CORRECT.

Accept and Submit

- A message will appear on the screen to confirm your SCOB form has been submitted successfully.
 - An email confirmation will be sent to the email address you supplied on the form.



- You have the option to **Print** a summary for your records.



HEREBY CERTIFY THAT ALL STATEMENTS ABOVE ARE TRUE AND CORRECT.

Print Exit

- Select **Exit** to sign out.