DHHS 116M
Rev. 11/2022

State of Utah
Department of Health and Human Services

EMPLOYER'S HEALTH INSURANCE INFORMATION

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Complete this form for each employed household member. Your employer's Human Resources representativ or department who manages employee benefits must complete it.

Employee's Name: _____
(First Name, Middle Initial, Last Name)

SSN (optional) or DOB: _____ eREP Case #: _____
Employer Name: _____ EIN: _____

☐ Yes ☐ No 1. Does your company offer health insurance?
If no, skip to section E, sign and return the form

2. When does your company's enrollment period begin? (mm/dd/yy): _____

SECTION A – ACCESS TO A QUALIFIED HEALTH PLAN:

☐ Yes ☐ No 3. Does your company offer any health plan that meets all of the following?

- The network deductible is $4,000 or less per person
- The plan pays at least 70% of an inpatient stay after employee meets in-network deductible
- The plan covers physician's visits, inpatient and outpatient hospital care, prescription drugs, laboratory services, preventative and wellness services, pregnancy, and childbirth
- Employer pays at least 50% of the monthly premium cost

Check one: 4. How do those plans cover abortion services?

☐ Does not cover abortion in any circumstances
☐ Plan covers elective abortion
☐ Covers abortion only in the case where the life of the mother would be endangered if the fetus were carried to term, or in the case of incest or rape (plan lists this exact language)
☐ Other, or if multiple plans offer differing coverages, please describe: _____

SECTION B – LEAST EXPENSIVE PLAN:

Complete the chart below for the plan that would cost the employee the least. Do not include the cost of dental, vision or other coverage if it is not included in the medical insurance premium amount.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	$	$
Employee + Spouse	$	$
Employee + Child	$	$
Family	$	$

Yearly Health Plan Deductible	
Individual Amount	$
Family Amount	$

If the employee is enrolled in health insurance skip to section D.

SECTION C – EMPLOYEE NOT ENROLLED IN HEALTH PLAN

☐ Yes ☐ No 5. Is the employee eligible to enroll in a health insurance plan?
If no, why not? _____

☐ Yes ☐ No 6. Was the employee eligible to enroll in the last open enrollment period?

☐ Yes ☐ No 7. Has this employee or any family member dropped or reduced coverage in the last 90 days?
If yes, name(s): _____
If yes, when did coverage end/change? (mm/dd/yy) _____

SECTION D – EMPLOYEE'S HEALTH PLAN INFORMATION:

☐ Yes ☐ No 8. Is this employee or any family member enrolled in any insurance plan offered?
If no, skip to section E
If yes, name(s) of person(s) enrolled: _____
When did coverage begin? (mm/dd/yy) _____
Insurance company and plan name: _____
Policy number: _____ Group number: _____
What is the check date for the first premium deduction? _____

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☐ Yes ☐ No 9. Is this health insurance plan a state employee benefit plan?

☐ Yes ☐ No 10. Does the employee's chosen health plan meet all of the following?

- The network deductible is $4,000 or less per person
- The plan pays at least 70% of an inpatient stay after employee meets in-network deductible
- The plan covers physician's visits, inpatient and outpatient hospital care, prescription drugs, laboratory services, preventative and wellness services, pregnancy, and childbirth
- Employer pays at least 50% of the cost

Check one: 11. How does the plan cover abortion services? This can typically be found in the paternity/pregnancy or exclusion sections of your policy

☐ Does not cover abortion in any circumstances
☐ Plan covers elective abortion
☐ Covers abortion only in the case where the life of the mother would be endangered if the fetus were carried to term, or in the case of incest or rape (plan lists this exact language)
☐ Other, please describe: _____

12. What is the monthly premium cost of this plan for just a single employee, not including any family members?

This plan's monthly premium cost for just a single employee	
Employee Cost	Employer Cost
$	$

13. Complete this chart for the benefits the employee is enrolled in. Fill out all applicable boxes:

How often is the premium deducted?
☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Other: _____

Premium deducted from this employee's check:			
	Medical	Dental	Vision
Employee	$	$	$
Employee + Spouse	$	$	$
Employee + Child	$	$	$
Family	$	$	$

Yearly Health Plan Deductible	
Individual Amount:	$
Family Amount:	$

14. Please list any children who have dental coverage: _____

SECTION E – SIGNATURE:

Name (please print): _____ Title: _____
Phone #: _____ Email Address: _____
Signature: _____ Date: _____

Please Return Completed Form To:
Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245
Fax: 1-801-526-9500 Toll-Free Fax: 1-877-313-4717