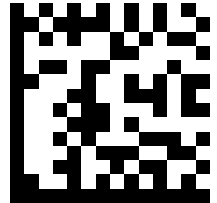


B Employer's Least Expensive Plan or Avenue H Default Plan



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Questions below refer to the **employer's least expensive** plan or the **Avenue H Default Plan**.

- Yes No
- Does the employee have to enroll in order to add their dependent(s)?
 - When will/did coverage begin? (mm/dd/yy) _____
 - When does the company's next open enrollment begin? (mm/dd/yy) _____
 - Complete the charts below. Do not include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	\$	\$
Employee + spouse	\$	
Employee + child	\$	
Family	\$	

Yearly Health Plan Deductible	
Individual amount	\$
Family amount	\$

C Employee's Health Plan Choice

Questions below refer to the plan that the employee has selected. Questions 3-7 refer to "in-network" benefits.

- Insurance company and plan name: _____
 - Policy number, if known: _____
- Yes No
- Is the deductible \$2,500 or less per individual?
 - Is the lifetime maximum benefit \$1,000,000 or more?
 - Does the plan pay at least 70% of an inpatient stay (after the deductible)?
 - What benefits are covered under this plan? (Check all that apply.)
 Physician visits Hospital inpatient services Pharmacy/Rx
- Yes No
- Does the plan cover abortion services?
 If yes, under what circumstances:
 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
 Other, please describe: _____
 - Complete these charts only if they are different from the charts in Section B above. Do not include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	\$	\$
Employee + spouse	\$	
Employee + child	\$	
Family	\$	

Yearly Health Plan Deductible	
Individual amount	\$
Family amount	\$

- Yes No
- Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s): _____

D Signature

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone: _____

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

Equal Opportunity Employer/Program: Auxiliary aids and services are available upon request to individuals with disabilities by calling (801) 526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.