DOH/Form 116M 05/2014
Case#:_____

D14214001630102

Employer's Health Insurance Information

- *This form MUST be completed by your employer or your company's Human Resources representative. Any blanks left on this form may delay the process.*
- *A form must be completed for each employed household member. You may copy this form.*
- *If you have general questions about this form or the medical programs, please call 1-866-435-7414.*

A General Information

Employee Information

Employee name _____ Employee SSN#_____
(first, m.i., last)

Employer Information

Employer Name: _____
EIN#:_____ Phone #:_____
Address:_____
street apt.# city state zip

Who can we contact about employee health coverage at this job?

Contact Name:_____
Phone #:_____ Email address:_____

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

☐Yes ☐No 2. Is your health insurance a state employee benefit plan?

☐Yes ☐No 3. Is your health insurance offered through Avenue H?

☐Yes ☐No 4. Is the employee eligible to enroll in any insurance plan offered?
If no, please explain: _____
If yes, when is/was the employee eligible to enroll? (mm/dd/yy)_____

☐Yes ☐No 5. Is the employee or any family member enrolled in any insurance plan offered?
If yes, name(s) of person(s) enrolled:_____
_____
_____

☐Yes ☐No 6. Has this employee or any family member dropped/changed coverage in the last six months?
If yes, name(s): _____
If yes, when did coverage end/change? (mm/dd/yy) _____

☐Yes ☐No 7. Does the employer offer a health plan that meets the *minimum value standard?

8. For the lowest-cost plan that meets the *minimum value standard offered **only to employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on the wellness programs:
a. How much would the employee have to pay in premiums for that plan? $_____
b. How often? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ quarterly ☐ yearly

☐Yes ☐No 9. Do you know what change the employer will make for the new plan year?
If yes, complete the following:
☐ Employer won't offer health insurance
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the *minimum value standard. (Premium should not reflect the discount for wellness programs. See question 8.
a. How much will the employee have to pay in premiums for that plan?
$_____
b. How often? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ quarterly ☐ yearly

***An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)**

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

D14214001630202

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

☐Yes ☐No 1. Does the employee have to enroll in order to add their dependent(s)?

2. When will/did coverage begin? (mm/dd/yy)_____

3. When does the company's next open enrollment begin? (mm/dd/yy) _____

4. 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.

1. Insurance company and plan name: _____

2. Policy number, if known: _____

☐Yes ☐No 3. Is the deductible $2,500 or less per individual?

☐Yes ☐No 4. Is the lifetime maximum benefit $1,000,000 or more?

☐Yes ☐No 5. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

6. What benefits are covered under this plan? (Check all that apply.)
☐ Physician visits ☐ Hospital inpatient services ☐ Pharmacy/Rx

☐Yes ☐No 7. 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:_____

8. 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 9. 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.