Case#: _____

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.

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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#: _____ E-mail 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 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 4. Is the employee or any family member enrolled in any insurance plan offered?
If yes, name(s) of person(s) enrolled: _____
_____

☐Yes ☐No 5. 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 6. Does the employer offer a health plan that meets the *minimum value standard?

7. 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 8. 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

Questions below refer to the **employer's least expensive plan.**

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☐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 chart 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 this chart only if it is different from the chart in Section B. **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