VERMONT HEALTH CONNECT
Find the plan that's right for you.

APPENDIX C
Employer Coverage Tool

APPLICANT Information

Applicant first name, middle name, last name & suffix (Jr., Sr., III, etc.)	Applicant Social Security number __ __ __ - __ __ - __ __ __ __

Health Coverage from Jobs

You **DO NOT** need to answer these questions unless someone in the household is eligible for health coverage from a job. Use this tool to help answer questions about any employer health coverage that you are eligible for (even if it is from another person's job, like a parent or spouse). Complete one tool for each employer that offers health coverage. Two copies of this form are provided. You can ask your employer to fill out this form. Remember, if you have your employer fill out this form, **you are still responsible for getting the information in with the application.**

EMPLOYEE Information

1. Employee first name, middle name, last name & suffix (Jr., Sr., III, etc.)	2. Employee Social Security number __ __ __ - __ __ - __ __ __ __

EMPLOYER Information

3. Business name	4. Employer Identification Number (EIN) __ __ - __ __ __ __ __ __ __
5. Business address	6. Business phone number ( ) –

7. City	8. State	9. ZIP code

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

11. Phone number (if different from above) ( ) –	12. Email address

13. Is the employee currently eligible for coverage offered by this employer, or will the employee become eligible in the next 3 months?

☐ **Yes** (Continue)
If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?

_____
(mm/dd/yyyy)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that covers an employee's spouse or dependent?

☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)
☐ No

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

16. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (do not 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 wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 17. If you do not know, STOP and return this form to employee.

17. What change will the employer make for the new plan year (if known)?

☐ Employer will not offer health coverage
☐ 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 reflect the discount for wellness programs. See question 16.)

a. How much will the employee have to pay in premiums for that plan? **$** _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

*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 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).