PERSON 1 Information

First name, middle name, last name & suffix (Jr., Sr., III, etc.)	Last 4 digits of your SSN __ __ __ __

You **DO NOT** need to answer these questions unless someone in the household is eligible for health coverage from a job, even if they don't accept the coverage. Attach a copy of this page for each job that offers health coverage.

You can ask your employer to fill out this form for you. **However, you are still responsible for submitting this form.**

Employee Information

1. Employee first name, middle name, last name & suffix (Jr., Sr., III, etc.)

Employer Information

2. Employer (or Company) name		**3.** Employer Identification Number (EIN)
4. Employer (or Company) address		**5.** Employer (or Company) phone number ( ) –
6. City/Town	**7.** State	**8.** ZIP code

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

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

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

If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?

Date (mm/dd/yyyy): _____

☐ Yes. **Continue to questions 13 through 16.**

☐ No. **STOP and return this form to employee.**

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

If yes, list the names of anyone else in the employee's household who's eligible for coverage from this job:

Name: _____ Name: _____

☐ Yes. **Which people?**

☐ Spouse ☐ Dependent(s)

☐ No. **Continue to question 14.**

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes. **Continue to question 15.**

☐ No. **STOP and return this form to employee.**

15. How much would the employee have to pay for the lowest cost plan offered **to the employee only** that meets the minimum value standard*? Do not include family plans.

If the employer has wellness programs, provide the premium that the employee would pay if they received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

If the plan year will end soon and you know that the health plans offered will change, **go to question 16**. If you do not know, **STOP and return this form to employee**.

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

16. What changes will the employer make for the new plan year?

☐ None

☐ Employer will not offer health coverage

☐ The premium amount will change for the lowest-cost plan available only to the employee that meets the minimum value standard*. *(Premium should only reflect discounts for tobacco cessation programs, see question 15.)*

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

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

**A health plan meets the minimum value standard if it pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.*