DETERMINATION OF AVAILABILITY OF EMPLOYER-BASED HEALTH INSURANCE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 167 (2-2008)

Clear Fields

Employer Name/Name of Business		
Business Address		
City	State	Zip Code

Employee Name	
Does the above-named employee have family/dependent health care coverage(hospital, doctor, and/or major medical) offered	☐ Yes ☐ No If YES, continue. If NO, please sign at the bottom.
TOTAL cost of the premium for the single plus family/dependent policy	How much of the total cost of premium is paid by the employer?
If family/dependent coverage is available, is the employee and/or family enrolled in this coverage?	☐ Yes ☐ No
If yes, list all individuals enrolled under this coverage	
If no, when is the next open enrollment period?	

Employer Signature	Date

Return this form to:

Social Services Name			
Address	City	State	Zip Code