# APPLICATION - APPENDIX A
DEPARTMENT OF HEALTH AND HUMAN SERVICES
ECONOMIC ASSISTANCE
SFN 1618 (9-2023)

## HEALTH COVERAGE FROM JOBS

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job.  Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.
**Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions.**
**You only need to include this page when you send in your application, not the Employer Coverage Tool.**

### EMPLOYEE INFORMATION

| 1.  Employee Name (First, Middle, Last) | 2.  Employee Social Security Number |
|---|---|
|  |  |

### EMPLOYER INFORMATION

| 3.  Employer Name | 4.  Employer Identification Number (EIN) |
|---|---|
| 5.  Address | 6.  Employer Telephone Number |

| 7.  City | 8.  State | 9.  ZIP Code |
|---|---|---|

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

| 11.  Telephone Number (if different from above) | 12.  Email Address |
|---|---|

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

☐ No (stop here and complete the rest of the application)      ☐ Yes (continue)

Date Eligible to Enroll in Coverage (if you are in a waiting or probationary period)

List the names of anyone else who is eligible for coverage from this job

| Name | Name | Name |
|---|---|---|

Tell us about the **health plan** offered by this employer

14.  Do the plans offered by the employer meet the minimum value standard? *
☐ YES (go to question 15)    ☐ No

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*?  Don't include family plans.

Employee would pay this premium (NOTE:  Enter the lowest amount the employee would pay for health coverage)

How often?
☐ Weekly  ☐ Every 2 Weeks  ☐ Twice a Month  ☐ Once a Month  ☐ Quarterly  ☐ Yearly

16.  **If other household members are listed for question 13:**  How much would the employee pay for the lowest-cost plan that covers the employee and the household members listed in question 13?  If the employer offers wellness programs, enter the premium that the employee would pay if the employee got the maximum discount for any tobacco cessation programs and didn't get any other discounts based on wellness programs.

Employee would pay this premium

How often?
☐ Weekly  ☐ Every 2 Weeks  ☐ Twice a Month  ☐ Once a Month  ☐ Quarterly  ☐ Yearly

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

# EMPLOYER COVERAGE TOOL

Use this tool to help answer questions in Appendix A about any employer health coverage that you're eligible for (even it it's from another person's job, like a parent or spouse).  The information in the numbered boxes below match the boxes on Appendix A.  For example, the answer to question 14 on this page should match question 14 on Appendix A.

Write your name and Social Security Number in boxes 1 and 2 and ask the employer to fill out the rest of the form.
Complete one tool for each employer that offers health coverage.

## EMPLOYEE INFORMATION

The **employee** needs to fill out this section.

| 1.  Employee Name (First, Middle, Last) | 2.  Employee Social Security Number |
|---|---|

## EMPLOYER INFORMATION (**ask** the **employer** for this information)

| 3.  Employer Name | 4.  Employer Identification Number (EIN) |
|---|---|
| 5.  Address | 6.  Employer Telephone Number |

| 7.  City | 8.  State | 9.  ZIP Code |
|---|---|---|

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

| 11.  Telephone Number (if different from above) | 12.  Email Address |
|---|---|

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

☐ No (stop here and return this form to employee)          ☐ Yes (continue)

Date Eligible to Enroll in Coverage (if the employee is not eligible today, including as a result of a waiting or probationary period)

Tell us about the **health plan** offered by this employer

14.  Do the plans offered by the employer meet the minimum value standard? *
☐ YES (go 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*?  Don't include family plans.

Employee would pay this premium (NOTE:  Enter the lowest amount the employee would pay for health coverage)

How often?
☐ Weekly   ☐ Every 2 Weeks   ☐ Twice a Month   ☐ Once a Month   ☐ Quarterly   ☐ Yearly

16.  **If other household members are listed for question 13:**  How much would the employee pay for the lowest-cost plan that covers the employee and the household members listed in question 13?  If the employer offers wellness programs, enter the premium that the employee would pay if the employee got the maximum discount for any tobacco cessation programs and didn't get any other discounts based on wellness.

Employee would pay this premium

How often?
☐ Weekly   ☐ Every 2 Weeks   ☐ Twice a Month   ☐ Once a Month   ☐ Quarterly   ☐ Yearly

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