APPLICATION - APPENDIX A

DEPARTMENT OF HUMAN SERVICES
ECONOMIC ASSISTANCE
SFN 1618 (8-2013)

Clear Fields

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

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the 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 wellness programs.

How much would the employee have to pay in premiums for this plan?

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

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

☐ Employer won't 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 15)

How much will the employee have to pay in premiums for this plan?

How often?
☐ Weekly ☐ Every 2 Weeks ☐ Twice 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)

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 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

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

☐ No (go to question 14) ☐ Yes, which people? ☐ Spouse ☐ Dependent(s)

14. Does the employer offer a health plan that meets the minimum value standard? * ☐ No (STOP and return form to employee) ☐ Yes (go to question 15)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the 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 wellness programs.

How much would the employee have to pay in premiums for this plan?

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

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

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

☐ Employer won't 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 15)

How much will the employee have to pay in premiums for this plan?

How often?
☐ Weekly ☐ Every 2 Weeks ☐ Twice 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)