

APPENDIX A

Health Coverage from Jobs

Complete this appendix only if someone in the household is eligible for health coverage from a job, but is not enrolled. You must provide this information to complete this application. Attach a copy of this page for each job that offers coverage. **The employee can take this form to the employer that offers coverage to help answer these questions.**

EMPLOYEE Information

1. FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	2. EMPLOYEE DATE OF BIRTH (MM/DD/YYYY)
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EMPLOYER Information

3. EMPLOYER NAME		4. EMPLOYER IDENTIFICATION NUMBER (EIN)		
5. EMPLOYER ADDRESS			6. EMPLOYER PHONE NUMBER	
7. CITY		8. STATE	9. ZIP CODE	
10. Whom can we contact about employee health coverage at this job? (This information is not required but providing it will make it easier for us to contact the employer.)			11. PHONE NUMBER (if different from above)	
<p>12. Was the employee offered coverage through a job for the current plan year, or will the employee be eligible for coverage in the next three months? Note: Answer yes if the employee could have enrolled but did not, even if the employee did not want coverage or thought it was too expensive.</p> <p><input type="radio"/> Yes – continue answering the remaining questions</p> <div style="border: 1px solid black; padding: 5px;"> <p>12a. If the employee is in a waiting or probationary period, when could coverage begin? (Declining enrollment is not considered a waiting or probationary period.) (MM/DD/YYYY)</p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p>12b. List the names of anyone else that is eligible for coverage from this job.</p> </div> <p><input type="radio"/> No – stop here and go to STEP 3 in the application</p>				

Continue to Next Page 



Tell us about the health plan offered by this employer for the employee only.

13. Does the employer offer a health plan that pays at least 60 percent of allowed costs and covers most inpatient hospital and physician services (minimum value standard)?*

Yes No

a. What is the name of the lowest-cost plan offered **only to the employee** by the employer? _____

b. How much would the employee pay for this plan if the employee received the maximum discount for not using tobacco or any tobacco cessation program offered? \$ _____

c. How often? Weekly Every two weeks Twice a month Monthly Quarterly Yearly

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

Employer will not offer health coverage for employee.

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 discounts for not using tobacco and tobacco cessation programs. See question 13.)

a. How much would the employee pay for this plan? \$ _____

b. How often? Weekly Every two weeks Twice a month Monthly Quarterly Yearly

Date of change (MM/DD/YYYY): _____

Tell us about the health plan offered by this employer for family coverage.

15. Does the employer offer a family health plan that pays at least 60 percent of allowed costs and covers most inpatient hospital and physician services (minimum value standard)?*

Yes No

a. What is the name of the lowest-cost plan offered **for family coverage** by the employer? _____

b. How much would the employee pay for this plan if the employee received the maximum discount for not using tobacco or any tobacco cessation program offered? \$ _____

c. How often? Weekly Every two weeks Twice a month Monthly Quarterly Yearly

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

Employer will not offer health coverage for spouse or dependents.

Employer will start offering health coverage to employees' spouse or dependents or change the premium for the lowest-cost plan available for family coverage that meets the minimum value standard.* (Premium should reflect discounts for not using tobacco and tobacco cessation programs.)

a. How much would the employee pay for this plan? \$ _____

b. How often? Weekly Every two weeks Twice a month Monthly Quarterly Yearly

Date of change (MM/DD/YYYY): _____

* See Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986. The employer can tell you the answer to this question.

