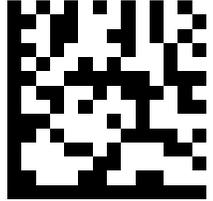


State of Utah
Department of Health
EMPLOYERS HEALTH INSURANCE INFORMATION



D11120900120102

Case #: _____

- Complete this form for each employed household member. Your employer’s Human Resources representative or department who manages employee benefits must complete it. You may copy this form.
- We may need the information from this form to help determine your eligibility for certain medical programs. If the form is not completed, it may delay the process. If you have general questions about this form or the medical programs, please call 1-866-435-7414.

A. EMPLOYEE INFORMATION

Employee Name: _____ Employee SSN#: _____
(first, m.i., last)

B. EMPLOYER INFORMATION

Employer Name: _____
EIN#: _____ Phone #: _____
Address: _____
street city state zip

Enter the information for the person or department who manages employee benefits and can provide information about benefits and coverage under the employer’s health insurance plan. We may need to contact this person if we need more information.

Contact Name: _____
Phone#: _____ E-mail address: _____

- Yes No 1). Does your company offer health insurance? If no, skip to section E. Sign and return the form.
- Yes No 2). Is the employee or any family member enrolled in any insurance plan offered?
If yes, name(s) of person(s) enrolled: _____
When did coverage begin? (mm/dd/yyyy) _____
- Yes No 3). Has the employee had an opportunity to enroll in health coverage offered by this employer?
If yes, when was the most recent open enrollment period for this employee? (mm/dd/yyyy) _____
- Yes No 4). Is this employee eligible to enroll?
If yes, when? (mm/dd/yyyy) _____
- Yes No 5). Is this health insurance plan a state employee benefit plan?
- Yes No 6). Has this employee or any family member dropped or reduced coverage in the last 90 days?
If yes, name(s): _____
If yes, when did coverage end/change? (mm/dd/yy) _____

C. EMPLOYER’S LEAST EXPENSIVE PLAN

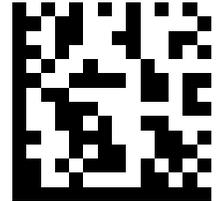
Complete the chart below for the employer’s least expensive plan. Do not include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee’s Portion	Company’s Portion
Employee	\$	\$
Employee + Spouse	\$	
Employee + Child	\$	
Family	\$	

Yearly Health plan Deductible	
Individual Amount	\$
Family Amount	\$

D. EMPLOYEE'S HEALTH PLAN CHOICE

Questions below refer to the plan that the employee has selected or are enrolled in. Questions 3-6 refer to "in-network" benefits.



D11120900120202

- 1). Insurance company and plan name: _____
- 2). Policy number and group number, if known: _____
- Yes No 3). Is the lifetime maximum benefit \$1,000,000 or more?
- Yes No 4). Does the plan pay at least 70% of an inpatient stay (after the deductible)?
- 5). What benefits are covered under this plan? (Check all that apply)
- Physician Visits Hospital inpatient services Pharmacy/Rx Well child exams Child Immunizations
- Yes No 6). Does the plan cover abortion services?
- If yes, check one:
- Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape. (Federal Definition)
- Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape or the mothers health would be irreversibly endangered. (State Definition)
- Other, please describe: _____
- Yes No 7). Does the employer offer dental coverage that the employee or their dependents are enrolled in or plan to enroll in?
- If yes, who? _____
- What date will/did coverage begin? (mm/dd/yyyy): _____

Complete this chart for the plan the employee has/will enroll in. Do not include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	\$	\$
Employee + Spouse	\$	
Employee + Child	\$	
Family	\$	

Yearly Health Plan Deductible	
Individual Amount	\$
Family Amount	\$

E. SIGNATURE

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone #: _____

Please return completed form to:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245
 Fax: 1-801-526-9500 Toll-Free Fax: 1-877-313-4717