

Case #: _____

Employer's Health Insurance Information

- This form MUST be completed by your employer or your company's Human Resources representative. Any blanks left on this form may delay the process.
- A form must be completed for each employed household member. You may copy this form.

A General Information

Employee Name : _____ SS#: _____

Company Name: _____ EIN: _____

Yes No 1. Does your company offer health insurance? If no, skip to section D. Sign and return the form.

Yes No 2. Is your health insurance offered through the Utah Health Exchange (UHE)?

Yes No 3. Is the employee eligible to enroll in any insurance plan offered?

If no, please explain: _____

If yes, when is/was the employee eligible to enroll? (mm/dd/yy) _____

Yes No 4. Is the employee or any family member enrolled in any insurance plan offered?

If yes, name(s) of persons enrolled: _____

Yes No 5. Has this employee or any family member dropped/changed coverage in the last six months?

If yes, name(s): _____

If yes, when did coverage end/change? (mm/dd/yy) _____

B Employer's Least Expensive Plan or UHE Default Plan

Questions below refer to the **employer's least expensive** plan or the **UHE Default Plan**.

Yes No 1. Does the employee have to enroll in order to add their dependent(s)?

2. When will/did coverage begin? (mm/dd/yy) _____

3. When does the company's next open enrollment begin? (mm/dd/yy) _____

4. Complete the chart below. **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	\$	

Employee Name: _____ SS or Case #: _____

C Employee's Health Plan Choice

Questions below refer to the plan that the employee has selected.

Questions 3-7 refer to "in-network" benefits.

1. Insurance company and plan name: _____

2. Policy number, if known: _____

Yes No 3. Is the deductible \$2,500 or less per individual?

Yes No 4. Is the lifetime maximum benefit \$1,000,000 or more?

Yes No 5. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

6. What benefits are covered under this plan? (Check all that apply.)

Physician visits Hospital inpatient services Pharmacy/Rx

Yes No 7. Does the plan cover abortion services?

If yes, under what circumstances:

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

Other, please describe: _____

8. Complete this chart only if it is different from the chart on the front page (section B). **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	\$ _____	_____

Yes No 9. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s): _____

D 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

If you have general questions about this form or the medical programs, please call 1-866-435-7414.