



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.

1 General Information

Employee Name : _____ SSN: _____

Company Name: _____ EIN: _____

- Yes No A. Does your company offer health insurance? If no, skip to Section 4. Sign and return the form.
- Yes No B. 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 C. Is the employee or any family member enrolled in any insurance plan offered?
If yes, name(s) of persons enrolled: _____

- Yes No D. 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) _____

2 Least Expensive Plan

Questions below refer to the least expensive plan offered at your company.

- Yes No A. Does the employee have to enroll in order to add their dependent(s)?
- Yes No B. When will/did coverage begin? (mm/dd/yy) _____
- Yes No C. When does the company's next open enrollment begin? (mm/dd/yy) _____
- Yes No D. Complete the chart below. Do NOT include the cost of dental, vision or other coverage if it is separate.

Employee Cost per Month	
Employee	\$ _____
Employee + spouse	\$ _____
Employee + child	\$ _____
Family	\$ _____

- Yes No E. What is the company's cost per month to insure the employee? \$ _____
- Yes No F. Is there a yearly deductible that the employee must pay before ANY claims are paid under this plan? (not the "out of pocket" cost or hospital deductible)
If yes, individual amount \$ _____
family amount \$ _____

3 Employee's Choice of Health Plan

Questions below refer to the plan the employee has selected. Questions B-H refer to "in-network" benefits.

Yes No A. Insurance company and plan name: _____

Yes No B. Is the deductible \$1000 or less per person?

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

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

E. 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 F. Is dental coverage offered for the employee's children?
If yes, name(s): _____

G. Complete this chart only if it is different from the chart on the front page (Section 2).

Employee Cost per Month	
Employee	\$
Employee + spouse	\$
Employee + child	\$
Family	\$

H. What is the company's cost per month to insure the employee? \$ _____

4 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:

UDOH BOA
PO Box 144102
Salt Lake City, UT 84114-4102
Fax: 801-538-6860