



Employer's Health Insurance Information

- This form **MUST** be completed by your employer or your company's Human Resources representative
- This form must be completed for each employed household member

Employee Name : _____ SSN: _____

Company Name: _____ EIN: _____

- Yes No 1. Does your company offer health insurance? (If no, please sign the back and return the form.)
- Yes No 2. Is the employee able to enroll in any insurance plan offered? If no, please explain:

- Yes No 3. Is the employee (or any family member) enrolled in any insurance plan offered?
If yes, please list the names of persons enrolled:

- Yes No 4. Has this employee (or any family member) dropped/changed coverage in the last six months? If yes, please list the name(s): _____
Date coverage ended/changed (mm/dd/yy): _____

For questions 5-10, please give information on the LEAST EXPENSIVE plan offered.

- Yes No 5. Does the employee have to enroll in order to add their dependents(s)?
- 6. Date the employee is eligible to sign up for insurance (mm/dd/yy): _____
- 7. Date coverage will begin (mm/dd/yy): _____
- 8. Date of next open enrollment, if applicable (mm/dd/yy): _____
- 9. a) Please complete the chart below regarding the cost of health insurance. **Do NOT** include the cost of dental, vision, or other coverage, if it is separate.
- b) Employee's costs are withheld: Monthly Twice a month Every two weeks Weekly

	Employee Cost	Employer Cost (per month)
Employee	\$	\$
Employee + spouse	\$	
Employee + 1 dependent	\$	
Employee + 2 dependents	\$	
Family	\$	

- Yes No 10. Is there a yearly deductible that must be met before any claims are paid under this plan?
If yes, amount: \$ _____

For questions 11-17, please give information on the plan the employee has selected. If it is the same plan as in questions 5-11, you do not need to complete the chart in question 16. Questions 12-15 refer to “in-network” benefits.

11. Insurance company and plan name: _____
- Yes No 12. Is the deductible \$1000 or less per person?
- Yes No 13. Does the plan pay at least 70% of an inpatient stay (after the deductible)?
- Yes No 14. Is the lifetime maximum benefit \$1,000,000 or more?
15. What benefits are covered under this plan? (Check all that are covered.)
- Physician visits Hospital inpatient services Pharmacy
- Well child exams Child immunizations

16. a) For this plan, please complete the chart below regarding the cost of health insurance. **Do NOT** include the cost of dental, vision, or other coverage, if it is separate.
- b) Employee’s costs are withheld: Monthly Twice a month Every two weeks Weekly

	Employee Cost	Employer Cost (per month)
Employee	\$	\$
Employee + spouse	\$	
Employee + 1 dependent	\$	
Employee + 2 dependents	\$	
Family	\$	

- Yes No 17. Is dental coverage offered for the employee’s children?
- If yes, please list the names of children enrolled: _____

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: _____

Return completed form to:

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

Or fax to: _____

If you have questions, contact: _____ at _____