

EMPLOYER SPONSORED HEALTH INSURANCE
REQUEST FOR INFORMATION

Your Employee may be eligible for help in paying for health insurance premiums, please provide information about the health insurance offered by your company and return it to the address at the bottom of this form.

Pursuant to Social Services Law Section 143, all employers of any kind doing business within the State of New York are required to furnish to the social services official, information about employees including information regarding health insurance coverage. Failure to do so may result in court action and penalties.

Employee Last Name:		First Name:		
Address:				
Is this individual currently enrolled in health insurance coverage through employment with you? <input type="checkbox"/> YES Complete Section A <input type="checkbox"/> NO Complete Section B *				
Does this individual have health insurance available to him/her now or in the future through employment with you? <input type="checkbox"/> YES Complete Section A <input type="checkbox"/> NO Complete Section B *				
SECTION A				
Employer Name:		Phone #:		
Insurance Carrier/Union Name:		Group #:		
Carrier Address:		Carrier Phone #:		
Name of person completing form:		Date:		
Employee/Enrollee	Coverage Type	Coverage Dates		Monthly Employee Premium Amount \$
	Family/Couple/Individual	Start Date	End Date	
1				
2				
3				
4				
5				

What are the standard: Deductibles \$ _____ Co-Insurance \$ _____ Co-payments \$ _____

Scope of Benefits: Please check all that apply and attach a plan summary

- | | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> Ambulatory Surgery | <input type="checkbox"/> Outpatient Services | <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Vision Care/ Eyeglasses | <input type="checkbox"/> Diagnostic Lab/ X-ray |
| <input type="checkbox"/> Inpatient Hospital Services | <input type="checkbox"/> Physician Services | <input type="checkbox"/> Transportation - Emergency | <input type="checkbox"/> Drug and Alcohol treatment | <input type="checkbox"/> Maternity Care |
| <input type="checkbox"/> Emergency Services | <input type="checkbox"/> Prescription Drug | <input type="checkbox"/> Dental | <input type="checkbox"/> Outpatient Mental Health | |

SECTION B

If employee is NOT enrolled in an employer-sponsored health care plan, check the applicable box and attach the information requested.

- | | |
|---|--|
| <input type="checkbox"/> Health insurance is not provided to our employees | <input type="checkbox"/> Employee is not currently eligible to enroll, but may enroll on (date) ____/____/____ |
| <input type="checkbox"/> Employee is not eligible for health care coverage because: _____

_____ | <input type="checkbox"/> Employee is eligible for health insurance, but has not enrolled* |

***Attach the plan(s) summary of benefits the employee, spouse, and dependents may be eligible for; and the employee cost for such benefits.**

If your employee is determined to be eligible to receive premium assistance in paying his/her share of the premium cost, would you accept direct payment from the Department of Social Services? YES___ NO___
If yes, Employer FEIN or Tax ID# is needed _____.

Please return this form within 15 days to the address below.

If you cannot upload this form onto your account, you may mail it to New York State of Health, P.O. Box 11727, Albany NY 12211. You may also fax your documents to 1-855-900-5557.

In order to help us identify the documents, please write your First and Last Name, Date of Birth, and Social Security Number on the documents you mail or fax to the Marketplace.

For Questions, Call: 1-855-355-5777 (TTY: 1-800-662-1220)