# EMPLOYER SPONSORED HEALTH INSURANCE
# REQUEST FOR INFORMATION

Your Employee may be eligible for help in paying for health insurance premiums, please provide information about health insurance offered by your company and return it to the address provided on page 1.

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? | |
| ☐ **Yes** Complete Section A | ☐ **No** Complete Section B * |
| Does this individual have health insurance available now or in the future through employment with you? | |
| ☐ **Yes** Complete Section A | ☐ **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 $ _____

Do you set aside funds in an HRA for your employee ? Yes ☐ No ☐

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

☐ 01 – COMP MED A
☐ 02 – COMP MED B
☐ 03 – INPATIENT
☐ 04 – HOME HEALTH
☐ 05 – EMRG ROOM
☐ 06 – CLINIC
☐ 07 – PHYS HOSP
☐ 08 – PHYS OFFICE
☐ 09 – NURSING HOME
☐ 10 – DRUG RECOVERY
☐ 11 – DRG MJ MED
☐ 12 – DRUG COPAY
☐ 13 – DME
☐ 14 – TRANSP
☐ 15 – DENTAL
☐ 16 – OPTICAL
☐ 17 – SUB AB INP
☐ 18 – SUB AB OUT
☐ 19 – PSCH INPAT
☐ 20 – PSCH OUT
☐ 21 – X-RAY
☐ 22 - HOSPICE
☐

**SECTION B**

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

☐ Health insurance is not provided to our employees

☐ Employee is not currently eligible to enroll, but may Enroll on (date) _____ / _____ / _____

☐ Employee is not eligible for health care coverage because: _____
_____
_____
_____

☐ 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.**

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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 _____.