



EMPLOYER COVERAGE TOOL

Use this tool to help answer questions about any employer health coverage that you are eligible for (even if it's from another person's job, like a parent or spouse).

Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage.



EMPLOYEE Information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last, & Suffix)	2. Social Security Number ____ - ____ - _____
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EMPLOYER Information

Ask the **employer** for this information.

3. Employer name	4. Employer Identification Number (EIN) ____ - _____
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5. Employer address

7. City	8. State	9. ZIP code
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6. Employer phone number () - Ext. _____	Phone Type: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
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10. Who can we contact about employee health coverage at this job?

11. Contact phone number (if different from above) () - Ext. _____	Phone Type: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
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12. Email address

Tell us about the **health plan** offered by this **employer**.

13. Does the employer offer a health plan that covers an employee's spouse or dependent(s)?

Yes. Which people? Spouse Dependent(s)

No.

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) **No** (STOP and return form to employee)

NEED HELP WITH FILLING THIS FORM? Visit ConnectforHealthCO.com or call us at **1-855-PLANS-4-YOU (1-855-752-6749)**. Para obtener una copia de este formulario en Español, llame **1-855-PLANS-4-YOU (1-855-752-6749)**. If you need help in a language other than English, call **1-855-PLANS-4-YOU (1-855-752-6749)** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-346-3432**.



Employer Coverage Tool - Continued

NAME OF EMPLOYEE: _____

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):

a. What is the name of the plan that is offered now? _____

b. What is the name of the plan that will be offered in the coverage year **?

c. How much would the employee have to pay in premiums for this plan?

\$ _____

d. How often? Weekly Every 2 weeks Twice a month Monthly
 Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year (if known)?

Nothing will change

Employer won't offer health coverage. To who? _____

Last day of coverage available? _____

Employer will start offering health coverage to employees.

To who? _____ 1st day of coverage? _____

Employer will change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard*.

Date of change? _____

a. How much would the employee have to pay in premiums for that plan?

\$ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly
 Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the employer pays for 60% of the allowed health plan benefits. If you are unsure if your employer-sponsored coverage meets the "minimum value standard" or the affordability standard, please contact your employer or Human Resources Representative. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

** The Calendar year in which your plan is active. (Ex. If applying in 2013 for coverage that begins in 2014, the coverage year is 2014.)
