Attachment C: Employer Insurance Form

COVERED CALIFORNIA

This form is only necessary for those who are applying for health insurance through a job. It is not necessary for some health insurance programs offered through Covered California , including Medi-Cal. If you are not sure whether or not to use this form, call Covered California to ask: **1-800-300-1506** (TTY: 1-888-880-4500).

If more than one job offers health coverage, use a separate form for each employer.

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

- ☐ Employer won't offer health coverage
- ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the ***minimum value standard.**** (Premium should reflect the discount for wellness programs.)

How much will the employee have to pay in premiums for that plan? **$** _____

How often? _____

☐ Weekly ☐ Every 2 weeks ☐ Quarterly
☐ Monthly ☐ Twice a month ☐ Yearly

Date of change _____

▶ Employee information

★ Fill in your name and Social Security number (SSN) *(optional)*. Then make a copy of this page or take the application to your employer. Ask your employer to fill in the rest of the page. If you copy the page, be sure to send it with your application.

Employee: First name	Middle name	Last name	Social Security number (SSN) ***(Optional)***
			__ __ __ – __ __ – __ __ __ __

▶ Employer information *Ask the employer for this information*

★ **Note for employer:** To complete the Covered California application, we need to know about health insurance that your employee or their dependents might be able to get from you. Please complete the information below, even if your company does not offer health insurance.

Employer name:		*Employer Identification Number (EIN)* __ __ – __ __ __ __ __ __ __
Employer address		Employer phone number
City	State	ZIP code

Who can we contact about employee health coverage at this job?

Phone number	Email address

☐ We do not offer health insurance. ☐ This employee does not qualify for coverage under our plan.

☐ The employee qualifies for coverage under our plan beginning on _____ *(start date)*.

What's the name of the lowest cost, self-only health plan this employee could enroll in at this job? Consider only those plans that meet the ***minimum value standard**** set by the Federal Patient Protection and Affordable Care Act of 2010. If you're not sure, ask your health insurance issuer.

Name: _____

☐ No plans meet the minimum value standard*.

How much would the employee have to pay in premiums for the lowest cost? **$**_____

How often? _____

☐ Weekly ☐ Every 2 weeks ☐ Quarterly
☐ Monthly ☐ Twice a month ☐ Yearly
☐ Other _____

**Minimum value standard* means that a plan pays at least 60% of the total cost of plan benefits provided to the employee. (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Go back to the application *to continue*

¿Preguntas?

Llame a Covered California al **1-800-300-1506** (TTY: 1-888-889-4500). La llamada es gratuita. Usted puede llamar de lunes a viernes de 8 a.m. a 6 p.m. y los sábados de 8 a.m. a 5 p.m. O visite **CoveredCA.com**.