ATTACHMENT

Form
Approved OMB

Health Coverage from Jobs

You **DON'T** need to answer these questions unless someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the **job** that offers coverage.

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

APPLICANT Information *List the person applying for Medical Assistance offered health coverage from a job*

1. Applicant name (First, Middle, Last)	2. Applicant Date of Birth (mm/dd/yyyy) _______ /______ /	3. Applicant Social Security Number _______ -______-

EMPLOYEE Information *Skip this section if the person listed above is also the Employee*

4. Employee name (First, Middle, Last)	5. Employee Date of Birth (mm/dd/yyyy) _______ /______ /	6. Employee Social Security Number _______ -______-

EMPLOYER Information

7. Employer name		8. Employer Identification Number (EIN) _____ -
9. Employer address		10. Employer phone number ( ) –
11. City	12. State	13. ZIP code
14. Who is the employer contact that can provide information about your employee health coverage? Name (First, Middle, Last)		
15. Phone number (if different from ( ) –	16. Email address	

20c. Date of change (mm/dd/yyyy): __________

* **An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the**

NEED HELP WITH YOUR APPLICATION? Visit gateway.ga.gov or call us at 1-877-423-4746. Para obtener una copia de este formulario en Español, llame **1-877-423-4746**. If you need help in a language other than English, call **1-877-423-4746** and tell the
customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-255-**

17. **Are you currently eligible for coverage offered by this employer, or will you become eligible in the next**

☐ **3 months? Yes** (Continue)

17a. If yes, please enter the start date (mm/dd/yyyy): ____ /_____ /_____

17b. If yes, please indicate your relationship to the Employee with access to coverage: ☐ Self ☐ Spouse

☐ Dependent List the names of anyone else listed on this application who is eligible for coverage from this job. ___________________________

Name:____ Relation to Employee: ♟ Spouse ♟

☐ Dependent Name:____Relation to Employee: ♟ Spouse ♟

Dependent

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

18. Does the employer offer a health plan that meets the minimum value standard*? ☐Yes ☐ No

19. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs and did not receive any other discounts based on wellness programs.

19a. How much would the employee have to pay in premiums for this plan? **$** ___

19b. How often? ☐Weekly ☐Every 2 weeks ☐Twice a month ☐Once a month ☐ Quarterly ☐Yearly

20. During the open enrollment period, what changes 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.*

20a. How much will the employee have to pay in premiums for that plan? **$** _____

20b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Once a month ☐ Quarterly ☐ Yearly

____

20c. Date of change (mm/dd/yyyy): ___________

* **An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)**

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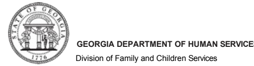
EMPLOYER COVERAGE TOOL



Form Approved
OMB No.

Use this tool to help answer questions in Attachment A about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). The information in the numbered boxes below match the boxes on Attachment
A. For example, the answer to question 18 on this page should match question 18 on Attachment A.

Write your name, date of birth, and Social Security number in boxes 1, 2, and 3 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)	2. Employee Date of Birth (mm/dd/yyyy) _______ /______ /	3. Employee Social Security Number _______ -______-

EMPLOYER Information

Ask the **employer** for this information.

17. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

17a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _________ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

7. Employer name		8. Employer Identification Number (EIN) _____ -
9. Employer address		10. Employer phone number ( ) –
11. City	12. State	13. ZIP code
14. Who is the employer contact that can provide information about your employee health coverage? Name (First, Middle, Last)		
14. Phone number (if different from above) ( ) –	16. Email address	

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

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

20c. Date of change (mm/dd/yyyy): ___________

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☐ Yes. Which people? ☐ Spouse ☐ Dependent(s) ☐ No (Go to question 18)

18. Does the employer offer a health plan that meets the minimum value standard*? ☐Yes ☐ No

19. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs and did not receive any other discounts based on wellness programs.

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20a. How much will the employee have to pay in premiums for that plan? **$** _____

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