APPENDIX A Health Coverage from Jobs

You **do not** 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. Take this form to your employer that offers coverage to help you answer these questions. You can use this information to complete your application.

EMPLOYEE Information

1. EMPLOYEE NAME (FIRST, MIDDLE, LAST)	2. EMPLOYEE SOCIAL SECURITY NUMBER

EMPLOYER Information

3. EMPLOYER NAME		4. EMPLOYER IDENTIFICATION NUMBER (EIN)
5. EMPLOYER ADDRESS		6. EMPLOYER PHONE NUMBER
7. CITY	8. STATE	9. ZIP CODE

10. Whom can we contact about employee health coverage at this job?

11. PHONE NUMBER (if different from above)	12. EMAIL ADDRESS

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next three months?
Note: If you declined or waived an offer of employer-sponsored coverage for the current plan year, you must answer yes. If you declined or waived an offer of employer-sponsored coverage for a prior plan year and there is no future option to enroll in an employer plan, answer no.

◯ Yes – continue

13a. If you are in a waiting or probationary period, when can you enroll in coverage (MM/DD/YYYY)?

List the names of anyone else that is eligible for coverage from this job.

◯ No – stop here and go to step 3 in the application

Tell us about the health plan offered by this employer.

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

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

a. What is the name of the lowest-cost plan offered by the employer? _____

b. How much would the employee have to pay in premiums for this plan? $ _____

c. How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

☐ Employer will not 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. See question 15.)

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

b. How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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)

Employer Coverage Tool

Use this tool to help answer questions in Appendix A about any employer health coverage that you are eligible for (even if it is from another person's job, like a parent's or spouse's). The information in the numbered boxes below matches the information in the boxes on Appendix A. For example, the answer to question 14 on this page should match the answer to question 14 on Appendix A. 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

1. EMPLOYEE NAME (FIRST, MIDDLE, LAST)	2. EMPLOYEE SOCIAL SECURITY NUMBER

EMPLOYER Information

3. EMPLOYER NAME		4. EMPLOYER IDENTIFICATION NUMBER (EIN)
5. EMPLOYER ADDRESS (The marketplace will send notices to this address)		6. EMPLOYER PHONE NUMBER
7. CITY	8. STATE	9. ZIP CODE

10. Whom can we contact about employee health coverage at this job?

11. PHONE NUMBER (if different from above)	12. EMAIL ADDRESS

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

◯ Yes – continue

13a. 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)

◯ No – STOP and return form to employee

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?

◯ Yes – which people? ☐ Spouse ☐ Dependent(s) ◯ No – go to question 14

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

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

a. What is the name of the lowest-cost plan offered by the employer? _____

b. How much would the employee have to pay in premiums for this plan? $ _____

c. How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year?

☐ Employer will not 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. See question 15.)

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

b. How often? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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)

NEED HELP WITH THIS APPLICATION? Visit **www.mnsure.org** or call us at **855-366-7873**. If you need help in a language other than English, tell us the language you need. We will get you help at no cost to you.