ATTACHMENT C

REQUEST FOR INFORMATION
EMPLOYER SPONSORED HEALTH INSURANCE

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 Name:

Address:

Does this individual have health insurance coverage through employment?
Yes ☐
No ☐

If YES, please complete Section A below. If NO, please complete Section B, reverse side

SECTION A

Carrier/Union Name: Policy No:

Address: Phone No:

Employee/Enrollee	Coverage	Coverage		Premium Cost to Employee
	Family/Couple/Individual	Start Date	End Date	
1				
2				
3				
4				
5				

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

☐ Inpatient Hospital Services
☐ Outpatient Services
☐ Physician Services
☐ Ambulatory Surgery
☐ Maternity Care
☐ Outpatient Mental Health
☐ Drug and Alcohol Treatment
☐ Emergency Services
☐ Prescription Drug
☐ Durable Medical Equipment
☐ Dental
☐ Transportation-Emergency
☐ Vision Care/Eyeglasses
☐ Diagnostic Lab / X-Ray

What are the standard: Deductibles _____

Co-Insurance _____

Co-payments _____

SECTION B

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

A. ☐ Health insurance is not provided to our employees

B. ☐ Employee is not currently eligible to enroll, but may enroll on ___/___/_____

C. ☐ Employee is not eligible for health care coverage; please explain
_____
_____
_____
_____

D. ☐ Employee is eligible for health insurance, but has not enrolled *.

*** Attach the plan or plans, including the scope of benefits the employee would be eligible for, along with costs for Family, Couple, and Individual coverage, as applicable.**

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 Service? YES___ NO___

Name of person completing form _____

Company Name and Title_____

Phone Number _____

Date _____

Return this completed form by __/__/____

Return form to: _____
_____
_____