New York State Department of Health
Division of Coverage and Enrollment

EMPLOYER SPONSORED HEALTH INSURANCE REQUEST FOR INFORMATION

Your Employee may be eligible for help in paying for health insurance premiums, please provide information about the health insurance offered by your company and return it to the address at the bottom of this form.

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 Last Name:	First Name:
Address:	

Is this individual currently enrolled in health insurance coverage through employment with you?
☐ **YES** Complete Section A ☐ **NO** Complete Section B *
Does this individual have health insurance available to him/her now or in the future through employment with you?
☐ **YES** Complete Section A ☐ **NO** Complete Section B *

SECTION A

Employer Name:	Phone #:
Insurance Carrier/Union Name:	Group #:
Carrier Address:	Carrier Phone #:
Name of person completing form:	Date:

Employee/Enrollee	Coverage Type	Coverage Dates		Monthly Employee Premium Amount $
	Family/Couple/Individual	Start Date	End Date	
1				
2				
3				
4				
5				

What are the standard: Deductibles $_____Co-Insurance $_____Co-payments $_____

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

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

SECTION B

If employee is NOT enrolled in an employer-sponsored health care plan, check the applicable box and attach the information requested.

☐ Health insurance is not provided to our employees
☐ Employee is not eligible for health care coverage because: _____
_____
_____
_____
☐ Employee is not currently eligible to enroll, but may enroll on (date) _____/_____/_____
☐ Employee is eligible for health insurance, but has not enrolled*****

***Attach the plan(s) summary of benefits the employee, spouse, and dependents may be eligible for; and the employee cost for such benefits.**

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 Services? YES___ NO___
If yes, Employer FEIN or Tax ID# is needed _____.

Return this completed form by ___/___/___
Return form to:
Social Service District Name: _____
Address: _____
_____
_____
Or Fax to: _____

For Questions, Call: