NEW YORK STATE DEPARTMENT OF HEALTH
Division of Eligibility and Marketplace Integration

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

Name of person completing form: _____ Phone: (____) ____ - ____ Date: ____/____/____

Employer Name: _____

Insurance Carrier/Union Name: _____ Carrier Phone: (____) ____ - ____

Carrier Address: _____ Group # _____ Policy # _____

Name of Covered Individuals	Family, Couple, or Individual Coverage?	Health, Dental, or Vision Plan?	Eligibility Start Date	Monthly Employee Premium
				$
				$
				$
				$

What is the standard: Deductible $_____ Co-Insurance $_____ Co-payments $_____
Attach a separate piece of paper if additional space is needed.

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

☐ Inpatient Hospital	☐ Outpatient Services	☐ Physician – Hospital	☐ Physician – Office	☐ Emergency Services
☐ Home Health Services	☐ Durable Medical Equipment	☐ Vision Care/ Eyeglasses	☐ Inpatient Substance Abuse Treatment	☐ Outpatient Substance Abuse Treatment
☐ Diagnostic Lab/Xray	☐ Psychiatric Inpatient	☐ Psychiatric Outpatient	☐ Nursing Home	☐ Hospice
☐ Medical Transport	☐ Dental	☐ Prescription Drug	☐ Clinic	

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 currently eligible to enroll, but may enroll on (date) ____/____/____

☐ Employee is not eligible for health care coverage because: _____

☐ 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 the 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 New York State of Health? ☐ YES ☐ NO If yes, Employer FEIN or Tax ID# _____

Return this completed form by:	Return this completed form to:	Or fax to:	For questions, call:
____/____/____	_____ Social Service District Name _____ Address	_____	_____