Additional Information about Your Access to Employer Sponsored Health Insurance Coverage

In order to determine your continued eligibility for MassHealth for you and members of your household, we need more information from you AND your employer about your access to employer sponsored health insurance coverage.

You must cooperate in providing information necessary to maintain eligibility, including obtaining or maintaining available health insurance or your MassHealth benefits may be terminated.

Do not enroll in any health plan through your employer until we have reviewed the plan to meet Premium Assistance program standards. We will send you a letter to tell you if you have to enroll in a plan if we decide a plan offered through your employer meets program requirements.

INSTRUCTIONS –

1. Complete **Part 1: Member Information** section and sign below.
2. Have your employer complete **Part 2: Employer Sponsored Health Insurance Information**.
3. Return your completed form by the deadline on your notice. Include the Summary of Benefits from your employer if one has been provided to you. If your employer does not complete the form, you must still complete and return Part 1 by the deadline on your notice. You can return your form in one of the following ways:

   Mail: MassHealth
   Attn: ESI
   PO Box 7
   Quincy, MA 02171

   OR

   Fax: 617-847-3148

PART 1 Member Information (You must complete this section.)

1. First name, middle name, last name, and suffix

2. Date of birth | 3. MassHealth Member ID Number:

4. Are you currently working? ☐ Yes (complete question 4a) ☐ No (go to question 5)

   4a. If **yes**, Employer name and address

   Wages/tips (before taxes) $ _____ ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
   (Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)
   Date you started getting these wages/tips _____ Average number of hours worked each WEEK _____
   Is this job a sheltered workshop? ☐ Yes ☐ No
   Are you seasonally employed? ☐ Yes ☐ No If yes, how many months do you work each calendar year? _____
   If you have more jobs and need more space, attach another sheet of paper.
   Yearly income: 1. What is your total expected income for the current calendar year? _____
   2. What is your total expected income for next calendar year, if different?_____

5. If no, does your spouse or domestic partner, or parent of a child under age 19 living in your household currently work? ☐ Yes ☐ No
   If you answered **yes** to question 4 or 5, give this form to your/their employer to complete **Part 2: Employer Sponsored Health Insurance Information**. If **no**, send a copy of a bill or statement from your insurance company showing your monthly premium cost and a Summary of Benefits.
   If you answered no to question 4 and 5, sign and return this form. You must contact MassHealth at 1-800-841-2900 or TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled to report any employment and /or income changes.

6. SIGNATURE:
   I certify under pains and penalty of perjury that what is stated on this form is correct and complete to the best of my knowledge.

   Signature of head of household or authorized representative Date

Member name	Date of birth

PART 2 Employer Sponsored Health Insurance Information
(To be completed by your employer.)

If you have questions about how to complete this form, please call 1-800-862-4840.

1. Employer name

2. Employer FEIN/Tax ID Number:

3. Human Resources Contact Information:
   Name: _____
   Address: _____
   Contact Telephone Number: _____
   Contact email address (optional) _____

4. Do you offer health insurance to your employees? ☐ Yes ☐ No
   If **no**, sign below and return this form to the employee.
   If **yes**, you must complete all questions below.

5. Is this employee eligible to enroll in health insurance? (check one)
   ☐ This employee is not offered health insurance.
   ☐ This employee is currently offered health insurance.
   ☐ This employee will be offered health insurance on _____ (mm/dd/yyyy)

6. Please tell us your open enrollment dates:

7. If the employee is currently offered insurance or will be offered insurance, please complete the chart below. A Summary of Benefits for each plan the employee has access to must be provided. In lieu of completing the chart below, a detailed rate sheet listing both the employer and per pay period employee contribution for every health plan you offer can be submitted. You will still need to confirm the pay period frequency. Please check off if you will be including this document in your submission.

☐ Rate Sheet Included

Name of Plan	Health Plan #1	Health Plan #2	Health Plan #3	Health Plan #4
Level of Coverage Offered	☐ Individual ☐ Dual ☐ Couple ☐ Family	☐ Individual ☐ Dual ☐ Couple ☐ Family	☐ Individual ☐ Dual ☐ Couple ☐ Family	☐ Individual ☐ Dual ☐ Couple ☐ Family
Family Coverage Total Monthly Premium				
Employee Contribution Please list the Per Pay Period Rate	Individual _____ Dual _____ Couple _____ Family _____	Individual _____ Dual _____ Couple _____ Family _____	Individual _____ Dual _____ Couple _____ Family _____	Individual _____ Dual _____ Couple _____ Family _____
Employer Contribution Please express as a percentage. If the same for all plans, you only need to complete the "All" section.	Individual _____ Dual _____ Couple _____ Family _____ All: _____	Individual _____ Dual _____ Couple _____ Family _____ All: _____	Individual _____ Dual _____ Couple _____ Family _____ All: _____	Individual _____ Dual _____ Couple _____ Family _____ All: _____
Pay Period Frequency	☐ Weekly ☐ Biweekly ☐ Other _____	☐ Weekly ☐ Biweekly ☐ Other _____	☐ Weekly ☐ Biweekly ☐ Other _____	☐ Weekly ☐ Biweekly ☐ Other _____
Open Enrollment Dates				

8. EMPLOYER SIGNATURE:
   I certify under pains and penalty of perjury that what is stated on this form is correct and complete to the best of my knowledge.

Signature of person completing this form Date