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

# NYSOH-Employer Sponsored Health Insurance Request For Information

You may be eligible to receive assistance with payment of health insurance premiums. Ask your employer to complete the information on the back of this page about the health insurance offered to employees. Return the completed form along with supporting documentation, if required, within fifteen (15) days.

## How to Submit Documentation to New York State of Health

You may submit the documentation in the following ways:

- Log into your account at www.nystateofhealth.ny.gov to upload documentation;
- Fax the documentation to 1-855-900-5557; or
- Mail the appropriate documentation to:

  New York State of Health
  PO Box 11727
  Albany, New York 12211

**In order to help us identify the documents, please write your First and Last Name, Date of Birth, your Marketplace ID and Account ID on the documents. You may mail or fax the documents to the Marketplace.**

**New York State of Health is unable to return documents sent for verification. Please send a copy of the original document and keep the original for your records.**

If you have questions regarding this letter, please contact us right away. You can call New York State of Health at
1-855-355-5777
(TTY: 1-800-662-1220)

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# NYSOH – 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. It will be used to determine if New York State can pay for the employee's share of the premium. 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 and the NYSoH, 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 form to: | Or fax to: | For questions, call: |
|---|---|---|
| New York State of Health<br>P.O. Box 11727<br>Albany, New York 12111 | 1-855-900-5557 | 1-855-355-5777<br>(TTY: 1-800-662-1220) |