

Qualified Family Members Information

1. Name: _____
Last First M.I.
 SSN/TIN: _____
 Date of Birth (mm/dd/yyyy): _____
 Relationship: Spouse: _____ Child: _____ Other: _____

2. Name: _____
Last First M.I.
 SSN/TIN: _____
 Date of Birth (mm/dd/yyyy): _____
 Relationship: Spouse: _____ Child: _____ Other: _____

3. Name: _____
Last First M.I.
 SSN/TIN: _____
 Date of Birth (mm/dd/yyyy): _____
 Relationship: Spouse: _____ Child: _____ Other: _____

4. Name: _____
Last First M.I.
 SSN/TIN: _____
 Date of Birth (mm/dd/yyyy): _____
 Relationship: Spouse: _____ Child: _____ Other: _____

Are you, or any qualified family member listed above, **enrolled** in a health plan maintained by an employer or former employer that pays at least 50% of the cost of coverage (this includes any amount contributed on a pre-tax bases)?..... Yes No

If Yes, Who: _____

Are you, or any qualified family member listed above, **entitled** to Medicare Part A? Yes No

If Yes, Who: _____

Are you, or any qualified family member listed above, **enrolled** in Medicare Part B? Yes No

If Yes, Who: _____

Are you, or any qualified family member listed above, **enrolled** in Medicaid?..... Yes No

If Yes, Who: _____

Are you, or any qualified family member listed above, **entitled** to health coverage through TRICARE/CHAMPUS?..... Yes No

If Yes, Who: _____

Are you enrolled in the 65% COBRA premium Reduction Program (AKA ARRA) ... Yes No

If Yes, Who: _____

¹Is any qualified family member listed above, **enrolled** in Utah's Children's Health Program (CHIP)?
..... Yes No

If Yes, Who: _____

Are you, or any qualified family member listed above, **enrolled** in the Federal Employees Health Benefits Program (FEHBP)?..... Yes No

If Yes, Who: _____

Are you **enrolled** in a health plan maintained by your spouse's employer or former employer that pays at least 50% of the cost of coverage (This includes any amount contributed on a pre-tax basis)?..... Yes No

If Yes, Who: _____

Under penalties of perjury, I declare that the information furnished on this form with regard to any qualified family member(s), and myself, and any attachments to it, are true, correct, and complete. I understand that a knowing and willing false statement on this form can result in a disqualification from participating in the HCTC Bridge Program.

You need to let us know if the information provided on this application changes because it could affect your eligibility for the HCTC Bridge Program. Notify us if:

- Your Health plan premium changes
- Your Health plan administrator changes
- Your HCTC eligibility changes, for example you turn 65 and become qualified for Medicare or you apply for and become qualified for SSI, which entitles you to apply for Medicaid or Medicare
- If you lose your eligibility for the HCTC, so do your qualified family members
- HCTC eligibility of your qualified family members changes, for example your child becomes eligible for a State Children's Health Insurance Plan

You can report changes to the HCTC Bridge Program at 1-801-468-0135 or toll-free 1-877-529-5578.

By signing this statement, I also agree to allow the Utah Department of Workforce Services HCTC Bridge Program to share my eligibility status with my health plan administrator.

Signature (black ink)

Date

Printed Name

Date

Equal Opportunity Employer Program

Auxiliary aids and services are available upon request to individuals with disabilities by calling (801) 526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.

It is against the law for the Department of Workforce Services (DWS), a recipient of Federal financial assistance, to discriminate on the following bases:

- Against any individual in the United States, on the basis of race, color, religion, sex, national origin, age, disability, political affiliation or belief; and
- Against any beneficiary of programs financially assisted under Title I of the Workforce Investment Act of 1998 (WIA), on the basis of the beneficiary's citizenship/status as a lawfully admitted immigrant authorized to work in the United States, or his or her participation in any WIA Title I-financially assisted program or activity.

DWS must not discriminate in any of the following areas:

- Deciding who will be admitted, or have access, to any WIA Title I-financially assisted program or activity;
- Providing opportunities in, or treating any person with regard to, such a program or activity; or
- Making employment decisions in the administration of, or in connection with, such a program or activity.

What to Do If You Believe You Have Experienced Discrimination

If you think that you have been subjected to discrimination under a WIA Title I-financially assisted program or activity, you must file a complaint within 180 days from the date of the alleged violation with either:

The State of Utah, Department of Workforce Services Equal Opportunity Officer/Customer Relations at (801) 526-4390 or 1-800-331-4341, or in writing to either DWS or the Civil Rights Center, as listed below.

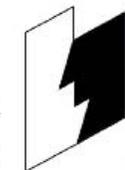
Equal Opportunity/Customer Relations
Department of Workforce Services
P.O. Box 45249
Salt Lake City, UT 84145-0249

The Director, Civil Rights Center (CRC)
U.S. Department of Labor
200 Constitution Ave. NW,
Room N-4123
Washington, DC 20210

If you file a complaint with DWS, you must wait either until DWS issues a written Notice of Final Action, or until 90 days have passed (whichever is sooner), before filing with the CRC. (see address above).

If DWS does not send you a written Notice of Final Action within 90 days of the day on which you filed your complaint, you do not have to wait for DWS to issue that Notice before filing a complaint with CRC. However, you must file your CRC complaint within 30 days of the 90-day deadline (in other words, within 120 days after the day on which you filed your complaint with DWS).

If DWS does give you a written Notice of Final Action on your complaint, but you are dissatisfied with the decision or resolution, you may file a complaint with the CRC. You must file your CRC complaint within 30 days of the date on which you received the Notice of Final Action.



DWS 09-15E-0604 NCR

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