DHHS 116E
Rev. 11/2022

State of Utah
Department of Health and Human Services

HEALTH INSURANCE ENROLLMENT INFORMATION

Please have your Human Resource person, or someone who manages employee benefits, complete this form once the employee has enrolled in an employer sponsored health insurance plan. Completing this form helps to confirm that the health plan selected by the employee meets certain criteria and may help your employee qualify for additional state benefits.

Employee's Name: _____
(First Name, Middle Initial, Last Name)

Employer's Name: _____ EIN: _____

HEALTH PLAN INFORMATION:

List the names of all family members enrolled under this plan: _____

When did coverage begin? (mm/dd/yy) _____

Insurance company and plan name: _____

Policy number: _____ Group number: _____

What is the check date for the first premium deduction? _____

☐ Yes ☐ No Does the employee's health plan selection meet all of the following?

- The network deductible is $4,000 or less per person
- The plan pays at least 70% of an inpatient stay after employee meets in-network deductible
- The plan covers physician's visits, inpatient and outpatient hospital care, prescription drugs, laboratory services, preventative and wellness services, pregnancy, and childbirth
- Employer pays at least 50% of the monthly premium cost

Check one: How does the selected plan cover abortion services? This can typically be found in the maternity/pregnancy or exclusion sections of your policy.

☐ Does not cover abortion in any circumstances
☐ Plan covers elective abortion
☐ Covers abortion only in the case where the life of the mother would be endangered if the fetus were carried to term, or in the case of incest or rape (plan lists this exact language)
☐ Other, please describe: _____

What is the monthly premium cost of this plan for just a single employee, not including any family members?

This plan's monthly premium cost for just a single employee	
Employee Cost	Employer Cost
$	$

Complete this chart for the benefits the employee is enrolled in. Fill out all applicable boxes:

How often is the premium deducted?

☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Other: _____

Premium deducted from this employee's check:			
	Medical	Dental	Vision
Employee	$	$	$
Employee + Spouse	$	$	$
Employee + Child	$	$	$
Family	$	$	$

Yearly Health Plan Deductible	
Individual Amount:	$
Family Amount:	$

SIGNATURE:

Name (please print): _____ Title: _____

Phone #: _____ Email Address: _____

Signature: _____

Please Return Completed Form To:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245
Fax: 1-801-526-9500 Toll-Free Fax: 1-877-313-4717

Equal Opportunity Employer/Program

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