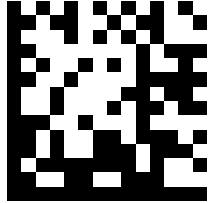


State of Utah  
Department of Health  
**HEALTH INSURANCE ENROLLMENT INFORMATION**



D02921900080101

Employer: 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, m.i., last)

Employer Name: \_\_\_\_\_ EIN #: \_\_\_\_\_

**Health Plan Information:**

1. 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: \_\_\_\_\_

2. What is the check date for the first premium deduction? \_\_\_\_\_

Yes  No

3. 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 employee's premium
- Lifetime maximum benefit is \$1,000,000 or more, or the plan has no maximum

Check One:

4. 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: \_\_\_\_\_

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

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

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

Premium deducted from this employee's check:

How often is the premium deducted? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a month <input type="checkbox"/> Monthly <input type="checkbox"/> Other (Specify): _____			
	Medical (Required)	Dental (Optional)	Vision (Optional)
Employee	\$	\$	\$
Employee + Spouse	\$	\$	\$
Employee + Child	\$	\$	\$
Family	\$	\$	\$

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

7. Please list any children who have dental coverage \_\_\_\_\_

**SIGNATURE:**

Name (please print): \_\_\_\_\_ Title: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

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