MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

Health Insurance Processing Center
PO Box 4405, Taunton, MA 02780 **Fax:** (617) 887-8770

Employer-sponsored Health Insurance Form

1. Please fill out the first section of this form.
2. Ask your employer to fill out the rest.
3. Mail or fax the form to the Health Insurance Processing Center. The address is at the top of this page. You must send the form by the date listed on the verification request.

EMPLOYEE — Who is the **employee?**

Employee name *(first, middle, last):*

Member ID:

Social Security number: __ __ __ – __ __ – __ __ __ __

EMPLOYER — The **employer** should fill out the rest of this form.

Company name:

Employer Identification Number (EIN): __ __ – __ __ __ __ __ __ __

Phone:

Street address:

City:

State:

ZIP code:

Name of person filling out this section *(first and last):*

Your title:

Your phone:

Your email:

With the health plan that this employer offers *(check one):*

☐ This employee **does not qualify** *You can skip the next questions, and sign and date this form.*

☐ This employee **qualifies**

☐ This employee **will qualify** on (*month, day, year):* _____

If this employee **qualifies** or **will qualify** for coverage:

What is the *lowest* cost individual plan this employee could enroll in? _____

How much would the employee pay in premiums? $ _____

How often? ☐ Each week ☐ Once a month ☐ Twice a month ☐ Once a year

☐ No plans meet the "minimum value" standard.

Minimum value *means that the health insurance plan pays at least 60% of the total costs of the average enrollee. The insurance company will know this information.*

Employer signature:

Date:

Questions?

Visit **MAhealthconnector.org** or call **1-877 MA ENROLL** (1-877-623-6765).
(TTY: 1-877-623-7773} Monday to Friday, 8 a.m. to 6 p.m. The call is free.