Access to Employer-Sponsored Health Insurance Coverage

ESI-1

In order to determine your continued eligibility for MassHealth for you and members of your household, we need more information from you AND your employer about your access to employer-sponsored health insurance coverage.

You must cooperate in providing information necessary to maintain eligibility, including obtaining or maintaining available health insurance, or your MassHealth benefits may be terminated.

Do not enroll in any health plan through your employer until we have reviewed the plan to see if it meets Premium Assistance program standards. We will send you a letter to tell you if you have to enroll in a plan if we decide a plan offered through your employer meets program requirements. **If you do not return this form by the deadline, your coverage may be ended for failure to cooperate per MassHealth regulations at 130 CMR 501.010.**

INSTRUCTIONS

1. Complete **Part 1: Member Information** section and sign below.
2. Have your employer complete Part 2: Employer-Sponsored Health Insurance Information section.
3. Return your completed form by the deadline on your notice. Include the Summary of Benefits from your employer if one has been provided to you. If your employer does not complete the form, you must still complete and return Part 1 by the deadline on your notice. You can return your form in one of the following ways:

   Mail: MassHealth Premium Assistance Program, 519 Somerville Ave., #372, Somerville, MA 02143
   Fax: (617) 451-1332

PART1: Member Information (You must complete this section.)

1. First name, middle name, last name, and suffix

2. Date of birth (DOB)	3. MassHealth Member ID #
4. Phone	5. Email

6. Address	7. City	8. State	9. Zip Code

10. Are you currently working? ☐ Yes (Complete the rest of the form) ☐ No (Go to question 11.)

10a. If **yes**, Employer name and address .....

Wages/tips (before taxes) $ ..... ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

(Subtract any pre-tax deductions, such as nontaxable health insurance premiums.)

Date you started getting these wages/tips ..... Average number of hours worked each WEEK .....

Are you seasonally employed? ☐ Yes ☐ No If yes, how many months do you work each calendar year? .....

If you have more jobs and need more space, attach another sheet of paper.

Yearly income: 1. What is your total expected income for the current calendar year? .....

2. What is your total expected income for next calendar year, if different? .....

10b. Are you and/or your family members enrolled in health coverage from this employer? ☐ Yes ☐ No

If yes, please provide the following:

Carrier Name ..... Policyholder Name .....

Policy Number ..... Group Number .....

Plan Effective Date ..... Policy Holder SSN .....

Name, DOB, and SSN of individuals covered by this policy .....

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If you answered yes to question 10, sign and date question 11 and give this form to the employer named in Question 10a to complete Part 2: Employer-Sponsored Health Insurance Information. After the employer completes Part 2, return the form to the address or fax number in the instructions.
If you answered no to question 10, sign and date question 11 and return this form to the address or fax number in the instructions.

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11. SIGNATURE

I certify under pains and penalty of perjury that what is stated on this form is correct and complete to the best of my knowledge.

Signature of head of household or authorized representative ..... Date .....

Printed name .....

If you have questions about obtaining health insurance through a job, the MassHealth Premium Assistance Program, or this form, call the MassHealth Premium Assistance Unit at **(800) 862-4840**.
If you have questions about your MassHealth eligibility or if you need to report changes to your application information (such as changes in employment), call the MassHealth Customer Service Center at **(800) 841-2900**; TTY **(800) 497-4648** (for people who are deaf, hard of hearing, or speech disabled).

PART2: Employer-Sponsored Health Insurance Information
(To be completed by your employer)

If you have questions about how to complete this form, please call (800) 862-4840. Did you file a completed employer Health Insurance Responsibility Disclosure form for your current plan year (a.k.a. rate year) through the DOR MassTaxConnect Web portal?
☐ Yes ☐ No.
If no, you must complete this entire form. If yes, only complete questions 1 through 6 and question 9 below.

1. Member name	Date of birth	MassHealth Member ID#

2. Employer name

3. Employer FEIN/Tax ID number

4. Human Resources contact information
Name ..... Address .....
Contact phone ..... Email (optional) .....

5. Do you offer health insurance to your employees? ☐ Yes ☐ No
If **no**, sign below and return this form to the employee. If **yes**, you must complete all questions below.

6. Is this employee enrolled in health insurance? ☐ Yes ☐ No

If yes, what plan is the employee enrolled in? .....

If yes, what tier is the employee enrolled in?
☐ Individual
☐ Employee plus child/children
☐ Employee plus 1
☐ Family

If no, is this employee eligible to enroll in health insurance? ☐ Yes ☐ No Not until (date) .....

7. Please provide your open enrollment dates.

8. If the employee is currently offered insurance or will be offered insurance, please complete the chart below. A Summary of Benefits for each plan the employee has access to must be provided. In lieu of completing the chart below, a detailed rate sheet listing both the employer and pay-period employee contribution for every health plan you offer can be submitted. You will still need to confirm the pay period frequency. Please check below if you will be including this document in your submission.

☐ Rate Sheet Included ☐ Summary of Benefits Included

Health Plan #1	Health Plan #2	Health Plan #3	Health Plan #4
Name of Plan			
Level of Coverage Offered			
☐ Individual ☐ Employee plus child/ children ☐ Employee plus one ☐ Family	☐ Individual ☐ Employee plus child/ children ☐ Employee plus one ☐ Family	☐ Individual ☐ Employee plus child/ children ☐ Employee plus one ☐ Family	☐ Individual ☐ Employee plus child/ children ☐ Employee plus one ☐ Family
Family Coverage Total Monthly Premium			
$	$	$	$ .....
Monthly Employee Contribution			
Individual $ ..... Employee plus child/ children $ ..... Employee plus one $ ..... Family $	Individual $ ..... Employee plus child/ children $ ..... Employee plus one $ ..... Family $	Individual $ ..... Employee plus child/ children $ ..... Employee plus one $ ..... Family $	Individual $ ..... Employee plus child/ children $ ..... Employee plus one $ ..... Family $ .....
Monthly Employer Contribution Amount			
Individual $ ..... Employee plus child/ children $ ..... Employee plus one $ ..... Family $	Individual $ ..... Employee plus child/ children $ ..... Employee plus one $ ..... Family $	Individual $ ..... Employee plus child/ children $ ..... Employee plus one $ ..... Family $	Individual $ ..... Employee plus child/ children $ ..... Employee plus one $ ..... Family $ .....
Open Enrollment Dates			
Plan Year Rate Effective Date			

9. EMPLOYER SIGNATURE

I certify under pains and penalty of perjury that what is stated on this form is correct and complete to the best of my knowledge.

Signature of person completing this form ..... Date .....

Printed name .....