Premium Assistance Program Application

ESI-2-0421

In order to determine eligibility for the MassHealth Premium Assistance Program 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.

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.

# 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, please 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

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.

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

Name of Health Plan #1

Level of Coverage Offered for Health Plan #1
Individual
Employee plus child/children
Employee plus one
Family

Family Coverage Total Monthly Premium for Health Plan #1

Monthly Employee Contribution for Health Plan #1
Individual $
Employee plus child/children $
Employee plus one $
Family $

Monthly Employer Contribution Amount for Health Plan #1
Individual $
Employee plus child/children $
Employee plus one $
Family $

Open Enrollment Dates for Health Plan #1

Name of Health Plan #2

Level of Coverage Offered for Health Plan #2
Individual
Employee plus child/children
Employee plus one
Family

Family Coverage Total Monthly Premium for Health Plan #2

Monthly Employee Contribution for Health Plan #2
Individual $
Employee plus child/children $
Employee plus one $
Family $

Monthly Employer Contribution Amount for Health Plan #2
Individual $
Employee plus child/children $
Employee plus one $
Family $

Open Enrollment Dates for Health Plan #2

Name of Health Plan #3

Level of Coverage Offered for Health Plan #3
Individual
Employee plus child/children
Employee plus one
Family

Family Coverage Total Monthly Premium for Health Plan #3

Monthly Employee Contribution for Health Plan #3
Individual $
Employee plus child/children $
Employee plus one $
Family $

Monthly Employer Contribution Amount for Health Plan #3
Individual $
Employee plus child/children $
Employee plus one $
Family $

Open Enrollment Dates for Health Plan #3

Name of Health Plan #4

Level of Coverage Offered for Health Plan #4
Individual
Employee plus child/children
Employee plus one
Family

Family Coverage Total Monthly Premium for Health Plan #4

Monthly Employee Contribution for Health Plan #4
Individual $
Employee plus child/children $
Employee plus one $
Family $

Monthly Employer Contribution Amount for Health Plan #4
Individual $
Employee plus child/children $
Employee plus one $
Family $

Open Enrollment Dates for Health Plan #4

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

End of the form ESI-2-0421