Marketplace Application Checklist *if you*:

- **Want to apply for Marketplace coverage**
- **Have job-based health insurance**

If you have job-based health insurance you like, you can keep it. You're considered covered. But if you'd like to explore your options, you may be able to change to Marketplace coverage. Whether you can get lower costs on your monthly premiums or out-of-pocket costs depends in part on the kind of coverage the employer offers.

When you use the Marketplace, you'll need information about your current job-based coverage (and any job-based coverage you're eligible for even if you haven't enrolled in it, including any coverage through a spouse's or parent's employer). You'll need some additional information to fill out the application. Use the checklist below to help you get ready.

- ☐ Social Security Number (or document number for legal immigrants)
- ☐ Employer and income information (for example, from pay stubs or W-2 forms—Wage and Tax Statements)
- ☐ Policy numbers for any current health insurance plans
- ☐ A completed **Employer Coverage Tool** (see page 2 of this checklist) for each job-based plan you're eligible for

You can apply for 2014 coverage as soon as October 1, 2013.

Stay up-to-date about the Marketplace. Visit **HealthCare.gov/subscribe** to get email or text updates that will help you get ready to apply.

Health Insurance Marketplace

CMS Product No. 11681
June 2013

Employer Coverage Tool

Health Insurance Marketplace

Use this tool to gather answers about any employer health coverage that you're eligible for (even if it's from another person's job, like a parent or spouse). You'll need this information even if you don't accept the employer insurance you're eligible for. **Write your name and Social Security number in boxes 1 and 2 and ask the employer to fill out the rest of the form. Complete one tool for each employer that offers health coverage that you're eligible for.**

EMPLOYEE Information

The **employee** needs to fill out this section.

1. Employee name (First, Middle, Last)	2. Social Security Number
	__ __ __ - __ __ - __ __ __ __

EMPLOYER Information

Ask the **employer** for this information.

3. Employer Name	4. Employer Identification Number (EIN)
	__ __- __ __ __ __ __ __ __
5. Employer address (the Marketplace will send notices to this address)	**6. Employer phone number** ( ) -

7. City	8. State	9. ZIP code

10. Who can we contact about employee health coverage at this job?

11. Phone number (if different from above)	12. Email address
( ) -	

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

- ☐ **Yes** (Continue)
  - 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
- ☐ **No** (STOP and return this form to employee)

Tell us about the **health plan** offered by this **employer.**

Does the employer offer a health plan that covers an employee's spouse or dependent?

- ☐ Yes. Which people? ☐ Spouse ☐ Dependent(s)
- ☐ No

(Go to question 14)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

- ☐ Employer won't offer health coverage
- ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy): _____

**An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)*

NEED HELP WITH YOUR APPLICATION? Visit **HealthCare.gov** or call us at **1-800-318-2596**. Para obtener una copia de este formulario en Español, llame **1-800-318-2596.** If you need help in a language other than English, call **1-800-318-2596** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-889-4325**.