# Employer Coverage Tool

Form Approved
OMB No. 0938-1213

Print or download 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 to complete your Marketplace application, even if you don't accept the employer insurance you're eligible for. **Write your name and Social Security Number (SSN) 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. Employee SSN |
|---|---|
| | ___ – ___ – ____ |

## EMPLOYER information

Ask the **employer** for this information.

| 3. Employer/company name | |
|---|---|
| Amphitheater Public Schools | |
| 4. Employer Identification Number (EIN) | 5. Employer phone number |
| 86-6000547 | (520) 696-5000 |

**Now, enter the information of the person or department who manages employee benefits. We may contact this person if we need more information:**

| 6. Person or department we can contact about employee health coverage | | |
|---|---|---|
| Janet Underwood | | |
| 7. Employer address (the Marketplace may send notices to this address) | | |
| 701 W Wetmore Rd | | |
| 8. City | 9. State | 10. ZIP code |
| Tucson | AZ | 85705 |
| 11. Phone number (if different from above) | 12. Email address | |
| ( ) – | junderwood@amphi.com | |

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

● **YES** (Continue)

○ **NO** (**EMPLOYER:** STOP and return this form to the employee. **EMPLOYEE:** return to your application for Marketplace coverage.)

**a. If the employee isn't eligible today, including as a result of a waiting or probationary period, when will the employee be eligible for coverage?** (mm/dd/yyyy)

__ / __ / ____

**b. Does the employer offer a health plan that covers this employee's spouse or dependent(s)?**

● **YES. If yes,** which people? ● Spouse ● Dependent(s)

○ **NO** (Go to question 14.)

**List the names of anyone else in the employee's household who's eligible for coverage from this job.**

Name

Name

Name

**continued on the next page**

## Tell us about the health coverage offered by this employer.

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

● **YES** (Go to question 15.) ○ **NO** (STOP and return this form to employee.)

15. How much would the employee have to pay for the lowest cost plan offered **to the employee only** that meets the minimum value standard*? Don't include family plans. **NOTE:** If the employer offers wellness programs, enter the premium that the employee would pay if the employee got the maximum discount for any tobacco cessation programs and didn't get any other discounts based on wellness programs.

a. Employee would pay this premium: **$** 12.00

**NOTE:** Enter the lowest amount the employee could pay for health coverage.

b. Employee would pay this amount: ○ Weekly ● Every 2 weeks ○ Twice a month ○ Once a month ○ Quarterly ○ Yearly

(Go to next question.)

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

○ Employer won't offer health coverage as of this date: (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

○ The premium amount will change for the lowest-cost plan that meets the minimum value standard* and is available to the employee only. (Premium should only reflect discounts for tobacco cessation programs. See question 15.)

a. Employee would pay this premium: **$**

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

c. Date of change: (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

● I don't know if the employer will make changes.

○ Employer won't make any of these changes.

*A health plan meets the minimum value standard if pays at least 60% of the total cost of medical services for a standard population and offers substantial coverage of hospital and doctor services. Most job-based plans meet the minimum value standard.

To request this form in Braille, large print, data CD, audio CD, or to request a qualified reader, you can call 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676. You can also make a request by sending a fax to 1-844-530-3676, an email to **AltFormatRequest@cms.hhs.gov**, or a letter to Offices of Hearings and Inquiries (OHI), Attn: CMS Alternate Format Team, 7500 Security Boulevard, Mail Stop S1-13-25, Baltimore, MD 21244-1850. Accommodations are available and provided at no cost to you. You have the right to file a complaint if you feel you've been discriminated against. Visit **cms.gov/About-CMS/Agency-Information/Aboutwebsite/CMSNondiscriminationNotice.html**, or call the Marketplace Call Center at 1-800-318-2596 for more information. TTY users should call 1-855-889-4325.