Georgia Access Employer-Sponsored Insurance (ESI) Coverage Tool

When applying for health coverage through Georgia Access, you are asked to provide information about any employer-sponsored coverage for which you or others on your application may be eligible. The *Georgia Access Employer-Sponsored Insurance (ESI) Coverage Tool* can be used to help organize and gather information about employers that offer traditional health coverage for anyone on your Georgia Access application. You will need the information in this form to complete the application, even if no one on your application is currently enrolled in coverage through their job (or the job of another person, like a spouse or parent); however, **submitting this form is not required to complete your Georgia Access application**. If you choose to use this tool, fill out this form for each job or employer that offers health coverage. You can visit GeorgiaAccess.gov/Learn-More/Eligibility-Employer-Insurance for more details if you have (or recently received an offer for) job-based insurance.

If someone on your application works for an employer that offers help paying for a health plan or health care expenses through a Health Reimbursement Arrangement (HRA), do not include these offers on this form.

If you need additional assistance with this form, including language or accessibility services (e.g., language translations, large print), please contact your Georgia Access enrollment channel or call the Georgia Access Contact Center at 888-687-1503.

STEP 1: EMPLOYEE INFORMATION

*Provide the information for the individual (**employee**) on your application who is offered job-based health coverage.*

Employee Information			
1. First Name	**2. Middle Name** *(if applicable)*	**3. Last Name**	**4. Suffix**
5. List the first and last name of each person in the employee's household and tell us if they are offered health coverage through the employer named in Step 2 below, even if they are not currently enrolled. *Only list household members who would be included on the employee's federal income tax return.*			
Household Member Name(s) *Please list the name(s) of the employee's household member(s) below:*		**Eligible for health coverage through this employer?**	
Name:		☐ **Yes**	☐ **No**
Name:		☐ **Yes**	☐ **No**
Name:		☐ **Yes**	☐ **No**
Name:		☐ **Yes**	☐ **No**

STEP 2: EMPLOYER INFORMATION

*Provide the information for the **employer** who offers job-based health coverage. You can ask the **employer** to fill out the sections below.*

Employer Information		
1. Employer Name	**2. Employer Identification Number (EIN)**	
Employer Contact Information *Enter the information of the person or department who manages employee benefits. We may contact this person if we need more information after you fill out your application.*		
3. Person or Department Who Manages Employee Benefits		
4. Email	**5. Primary Phone Number**	
6. Employer Address		
7. City	**8. State**	**9. Zip Code**
Employer – Job Based Health Coverage *Tell us about the health coverage offered by this employer*		
10. Does the employer offer a health insurance plan that meets the minimum value standard? *A health plan meets the minimum value standard if it 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.*	☐ **Yes**	☐ **No** *If no, do not complete the rest of this form.*
11. Does the employer offer plans that meet the minimum value standard to only the employee, but not the employee's family?	☐ **Yes** *If yes, only answer question 12; you do not need to answer question 13.*	☐ **No**

Employer – Job Based Health Coverage

Tell us about the health coverage offered by this employer

12. How much would the employee have to pay for the lowest cost plan offered to only the employee that meets the minimum value standard? Do not include family plans.

Amount	**Frequency of Payment**
$	☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Twice a Month ☐ Quarterly ☐ Yearly

13. If other household members are listed in Step 1: How much would the employee pay for the lowest cost plan offered by the employer that covers the employee *and* the household members listed and marked as eligible in Step 1?

If the employer offers wellness programs, enter the premium amount that the employee would pay if the employee received the maximum discount for any tobacco cessation programs and did not get any other discounts based on wellness programs.

Amount	**Frequency of Payment**
$	☐ Weekly ☐ Every 2 Weeks ☐ Monthly ☐ Twice a Month ☐ Quarterly ☐ Yearly