

When to use this form

Complete this form to request a determination of affordable coverage if:

- Someone in your household has access to or is currently covered by health coverage from a job **and**
- The insurance premium is unaffordable for your household.

Unaffordability is defined as a premium that costs more than the required contribution of your income. The required contribution is set annually by the Internal Revenue Service.

What happens next

You or your employer can send the complete, signed form to the address below. We will calculate whether your employer-sponsored coverage is considered affordable based on the information your employer provides.

Self Reliance Programs

PO Box 83720
Boise, ID 83720-0026
Fax: 1-866-434-8278
Email: MyBenefits@dhw.idaho.gov

Employee Information

First Name	Middle Name	Last Name	SSN
Address		City	State Zip Code
Phone Number	Email Address		

List everyone who is eligible for coverage from this job: _____

Did you miss your employer's open enrollment period and have to wait to enroll in health coverage until the next open enrollment period?

Yes. If yes, do NOT answer the question below. No

If you're in a waiting or probationary period, when can you enroll in coverage (MM/DD/YYYY)? _____

Health plan information (must be completed by employer)

1. Does the plan meet minimum value standard?* Yes No

2. Does the plan meet minimum essential coverage (MEC)? ** Yes No

Please complete this section for the lowest-cost plan that meets the minimum value standard* offered only to the employee (do not include family plans).

3. If the employer has wellness programs, provide the premium amount that the employee would pay if he/she received the maximum discount for any tobacco-cessation programs, and did not 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

Employer Information

Employer Name	Phone Number	Email Address
Name of Person Completing Form	Who may we contact about employee health coverage at this job (if different)?	

Signature (must be completed)

Under penalty of perjury, I swear or affirm the information I have provided is true and complete.

Signature of Employer _____

Date _____

*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.

**An employer-sponsored health plan meets the "minimum essential coverage" if it meets the essential health benefits as defined in 1302(a) of the Affordable Care Act.