REQUEST FOR HEALTH INSURANCE INFORMATION FROM EMPLOYER OR UNION

NYC Human Resources Administration Department of Social Services

MAP-2026Q.....Rev. 04/09/08

DATE: _____

EMPLOYEE'S NAME: _____

SOCIAL SECURITY NUMBER: _____

APPLICANT'S NAME: _____

CASE NUMBER: _____

_____
_____
_____

fold fold

Dear Employer/Union Representative:

The employee named above is covered by, or has applied for, Public Health Insurance such as Medicaid or Child Health Plus. In order to qualify, or remain eligible for such insurance, New York State Law (Chapters 318 of the Laws of 1981) requires this person to enroll in an employer or union-sponsored group health insurance plan if one is available.

Please complete this form so that we can determine if the employee can receive or continue to receive public health insurance. If you have any questions call: _____

Failure to comply with this request may result in the loss or denial of Public Health Insurance for the employee/applicant.

☐ Please return this form by _____ to the employee at _____
(Date) (Address of employee)

_____

☐ Please return this form in the enclosed postage paid envelope by _____
(Date)

IF THE APPLICANT IS CURRENTLY EMPLOYED, PLEASE COMPLETE THE FOLLOWING CHART FOR THE LAST FOUR WEEKS OF EMPLOYMENT:

	WEEK ENDING	GROSS SALARY	UNION DUES
1.			
2.			
3.			
4.			

Continue on Reverse

I. Is group health insurance available for this employee?

☐ **NO**. If no, sign, date and return form.

☐ **YES** If Yes, ☐ Employee only ☐ Employee and dependents. If dependents are covered, complete below

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____

If health insurance is available for the dependents and the dependents are not enrolled, please explain why:

_____

☐ Employee and/or dependents will be eligible for health insurance coverage effective_____

II.

EMPLOYER'S/UNION'S NAME	GROUP NO.
EMPLOYER'S/UNION'S ADDRESS	POLICY NO.
NANE OF INSURANCE CARRIER	COST TO EMPLOYEE $_____ ☐ Weekly ☐ Biweekly ☐ Monthly

III.

Date Coverage Began: _____ Extent of Coverage: Specify Policy A, Policy B, Both A & B: _____

POLICY	A	B	POLICY	A	B
MAJOR MEDICAL			COMP TO MEDICARE		
INPATIENT HOSPITAL			HOME HEALTH		
EMERGENCY ROOM			CLINIC		
PHYS IN-HOSPITAL			PHYS IN-OFFICE		
NURSING HOME			DRUGS-NO CARD		
DRUG MAJOR MEDICAL			DRUGS CO-PAY		
DME			TRANSPORTATION		
DENTAL			OPTICAL		
SUBSTANCE ABUSE			SUBSTANCE ABUSE		
PSYCH IN-PATIENT			PSYCH OUT-PATIENT		

EMPLOYER'S/ UNION'S SIGNATURE	TITLE	DATE
TELEPHONE NUMBER		

Thank you for your cooperation.