CHIP Coverage Coordination Disclosure Form

This Form is issued under Section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act of 2009, Section 701(f)(3)(B)(ii) of the Employee Retirement Income Security Act of 1974 (ERISA), Section 9801(f)(3)(B)(ii) of the Internal Revenue Code of 1986, and Section 2701(f)(3)(B)(ii) of the Public Health Service Act.

Please see the instructions prior to completing this Form.

The Plan Administrator may be fined under ERISA Section 502(c)(9)(B) for failure to properly complete this Form and return it (along with all required attachments) to the state/issuing agency within 30 days from the date listed in Part I.

Part I: To be Completed by the Issuing State

Section A. Issuing State Information.

Date: _____ Case or Identifying Number:_____

Issuing State/Agency: _____

Address: _____

_____

State/Agency Contact Person Name:_____

Phone: _____ Fax:_____

E-Mail: _____

Section B. Employee Information.

Employee Name: _____

Employee Address: _____

_____

Employee SSN Last 4 Digits: _____

Part II: To be Completed by the Plan Administrator

Section A. Group Health Plan Eligibility.

(1) Plan Sponsorship (check (i) or (ii) below).

(i) ☐ The employer/plan sponsor maintains a group health plan providing health coverage for (check all that apply):

- ☐ Employees
- ☐ Spouses
- ☐ Children
- ☐ Other (describe) _____

(ii) ☐ Employer/plan sponsor does not maintain any group health plan providing health coverage. (If you check this box, skip to Section D.)

(2) Eligibility (Check (i), (ii) or (iii) below).

(i) ☐ The Employee is currently eligible for health coverage under a group health plan maintained by the employer / plan sponsor.

(ii) ☐ The Employee is currently eligible for health coverage under the employer's / plan sponsor's group health plan but such coverage cannot begin until the completion of a waiting period.

The waiting period requirement is _____

The waiting period will end for the Employee on _____

(iii) ☐ The Employee is not currently eligible for health coverage under any group health plan maintained by the employer / plan sponsor because (check all boxes that apply and complete the required information in the blanks directly below, and then skip to Section D):

☐ The Employee is not among an eligible class (list eligible class(es) and employee's class)

_____

_____

☐ The Employee does not work enough hours

To be eligible for coverage, the Employee must work _____ hours in a (circle one) week / month / quarter.

This Employee works _____ hours in a (circle one) week / month / quarter.

☐ The Employee terminated employment on _____

☐ Other (describe requirement and reason Employee is not eligible):

_____

_____

(3) Enrollment Status (Check (i) and complete required information or check (ii).)

(i) ☐ The Employee is (or will be) enrolled in health coverage under the employer's / plan sponsor's group health plan.

Effective Date: _____

Carrier/Insurer Name: _____

Option Name/Type: _____

Coverage Tier: _____

Enrolled Spouse/Children/Dependent Names: _____

_____

_____

(ii) ☐ The Employee is not enrolled in health coverage under the employer's / plan sponsor's group health plan (and it may be unknown under which option the Employee may enroll).

(4) Anticipated Changes in Eligibility and Enrollment Status. (Check (i) or (ii) and complete required information.)

(i) ☐ The employer / plan sponsor is not aware of any anticipated changes in the Employee's eligibility and/or enrollment status that may occur within the next 60 days.

(ii) ☐ The employer / plan sponsor is aware of an anticipated change in the Employee's eligibility and/or enrollment status that may occur within the next 60 days. Describe Anticipated Change: _____

_____

_____

Section B. Benefits Offered Under the Group Health Plan.

If you completed Section A(3)(i) above, only complete Section B with respect to the coverage in which the Employee is enrolled. Alternatively, if you completed Section A(3)(ii) above, complete Section B with respect to each health coverage option in which the Employee is eligible to enroll.

If the employer / plan sponsor has more than three options for which the Employee is eligible to enroll, attach a separate document that includes all of the information requested in the chart below for the additional options and check here ☐.

See also Line 8 below, Section D and the instructions regarding various documents that must also be attached for all options.

Certain benefit options are exempt from this Form, including stand-alone dental and vision benefits (see instructions).

	Option #1	**Option #2**	**Option #3**
1. Insurer/ Carrier Name			
2. Option Name / Type			
3. ERISA Plan Name and Plan Number			

	Option #1	Option #2	Option #3
4. General Benefits / Services of Option	☐ Inpatient Hospital ☐ Outpatient Hospital ☐ Physician Surgical ☐ Physician Medical ☐ Lab and X-ray ☐ Well-baby/child ☐ Child Immunization ☐ Emergency ☐ Prescription Drug ☐ Mental Health	☐ Inpatient Hospital ☐ Outpatient Hospital ☐ Physician Surgical ☐ Physician Medical ☐ Lab and X-ray ☐ Well-baby/child ☐ Child Immunization ☐ Emergency ☐ Prescription Drug ☐ Mental Health	☐ Inpatient Hospital ☐ Outpatient Hospital ☐ Physician Surgical ☐ Physician Medical ☐ Lab and X-ray ☐ Well-baby/child ☐ Child Immunization ☐ Emergency ☐ Prescription Drug ☐ Mental Health
5. Dental Benefits	☐ Dental benefits provided as part of option ☐ Dental benefits provided as part of separate stand-alone option ☐ Dental benefits are not provided	☐ Dental benefits provided as part of option ☐ Dental benefits provided as part of separate stand-alone option ☐ Dental benefits are not provided	☐ Dental benefits provided as part of option ☐ Dental benefits provided as part of separate stand-alone option ☐ Dental benefits are not provided
6. Medical Individual / Family Deductible			
7. Medical Individual / Family Out-of-Pocket Maximum			
8. Additional Required Documents to be Attached to this Form	☐ SPD / SMM ☐ Insurance Certificate ☐ Enrollment Guide ☐ Other ____________ ____________________	☐ SPD / SMM ☐ Insurance Certificate ☐ Enrollment Guide ☐ Other ____________ ____________________	☐ SPD / SMM ☐ Insurance Certificate ☐ Enrollment Guide ☐ Other ____________ ____________________
9. Benefits Effective Through Listed Date			

Section C. Premiums Under the Group Health Plan.

If you completed Section A(3)(i) above, only complete Section C with respect to the coverage in which the Employee is enrolled. Alternatively, if you completed Section A(3)(ii) above, complete Section C with respect to each health coverage option in which the Employee is eligible to enroll.

Information required by Line 3 of this Section C can be furnished on a separate document that meets certain requirements (see instructions). If you are furnishing information required by Line 3 on a separate document, you must attach the separate document and check here ☐.

If the employer / plan sponsor has more than three options for which the Employee is eligible to enroll, you must attach a separate document that includes all of the information requested in the chart below for the additional options and check here ☐.

	Option #1	**Option #2**	**Option #3**
1. Insurer/ Carrier Name			
2. Option Name / Type			
3. Monthly Premiums			
(a) Single Coverage	Employee $_____ Employer $_____	Employee $_____ Employer $_____	Employee $_____ Employer $_____
(b) Employee + Spouse ☐ Not offered	Employee $_____ Employer $_____	Employee $_____ Employer $_____	Employee $_____ Employer $_____
(c) Employee + 1 child ☐ Not offered	Employee $_____ Employer $_____	Employee $_____ Employer $_____	Employee $_____ Employer $_____
(d) Employee + 2 child ☐ Not offered	Employee $_____ Employer $_____	Employee $_____ Employer $_____	Employee $_____ Employer $_____
(e) Employee & Family ☐ Not offered	Employee $_____ Employer $_____	Employee $_____ Employer $_____	Employee $_____ Employer $_____
(f) Other _____	Employee $_____ Employer $_____	Employee $_____ Employer $_____	Employee $_____ Employer $_____
(g) Other _____	Employee $_____ Employer $_____	Employee $_____ Employer $_____	Employee $_____ Employer $_____
(h) Other _____	Employee $_____ Employer $_____	Employee $_____ Employer $_____	Employee $_____ Employer $_____
4. Frequency of Payroll Deductions	☐ Biweekly 24 ☐ Biweekly 26 ☐ Weekly 48 ☐ Weekly 52 ☐ Semi-Monthly on _____ and _____ ☐ Monthly on _____	☐ Biweekly 24 ☐ Biweekly 26 ☐ Weekly 48 ☐ Weekly 52 ☐ Semi-Monthly on _____ and _____ ☐ Monthly on _____	☐ Biweekly 24 ☐ Biweekly 26 ☐ Weekly 48 ☐ Weekly 52 ☐ Semi-Monthly on _____ and _____ ☐ Monthly on _____
5. Premium Period to which the Payroll Deductions Apply	☐ Same Period ☐ Prior Period ☐ Next Period	☐ Same Period ☐ Prior Period ☐ Next Period	☐ Same Period ☐ Prior Period ☐ Next Period
6. Premiums paid through a cafeteria plan under IRC Section 125	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Additional flex credits / dollars available to employee through the cafeteria plan	☐ Yes (attach details) ☐ No	☐ Yes (attach details) ☐ No	☐ Yes (attach details) ☐ No

Section D. Plan Administrator and Contact Information.

Plan Administrator Name: _____

Address: _____

_____

Plan Administrator Representative / Contact Person Name*:

_____

Phone: _____ Fax:_____

E-Mail: _____

* The issuing state/agency may contact this person regarding this Form.

Under penalty of perjury, the plan administrator hereby declares that the plan administrator has examined this Form, including all accompanying attachments, and to the best of the plan administrator's knowledge and belief, it is true, correct and complete in all material respects.

Signature: _____ Date:_____

Print Name: _____ Title: _____

This Form requires a number of attachments, including a copy of each option's summary plan description (SPD) listed in Section B, Line 8. Make certain you have attached all required documents to this Form.

This Form, including all accompanying attachments, must be returned to the issuing state within 30 days from the date listed in Part I.