

To be completed by the employer or union’s human resources

EMPLOYEE’S COMPLETE LEGAL NAME	EMPLOYER/UNION
--------------------------------	----------------

Health insurance information

Please indicate the health insurance status for the employee and the employee’s dependent(s), and/or **submit copy of the current rates and summary of benefits** if available:

Is insurance offered to this employee, spouse and/or dependent(s)?		No	Yes — if yes, fill in below
Health insurance for employee	Offered, and accepted	Offered, but not accepted	
Health insurance for employee plus spouse	Offered, and accepted	Offered, but not accepted	
Health insurance for employee plus dependent(s)	Offered, and accepted	Offered, but not accepted	
NAMES OF THE COVERED DEPENDENTS AND THEIR RELATIONSHIP TO THE EMPLOYEE			
DATE EMPLOYEE WAS FIRST ELIGIBLE FOR INSURANCE	DATE YOUR OPEN ENROLLMENT PERIOD BEGINS	DATE YOUR OPEN ENROLLMENT PERIOD ENDS	GROUP NUMBER FOR POLICY
NAME OF INSURANCE COMPANY			
COSTS			
Cost of insurance for the employee	EMPLOYEE PAYS \$ _____ PER _____	EMPLOYER/UNION PAYS \$ _____ PER _____	TOTAL COST \$ _____ PER _____
Cost of insurance for employee plus spouse	EMPLOYEE PAYS \$ _____ PER _____	EMPLOYER/UNION PAYS \$ _____ PER _____	TOTAL COST \$ _____ PER _____
Cost of insurance for employee plus dependents	EMPLOYEE PAYS \$ _____ PER _____	EMPLOYER/UNION PAYS \$ _____ PER _____	TOTAL COST \$ _____ PER _____

Employer signature

NAME OF PERSON COMPLETING THIS FORM (PLEASE PRINT)	TITLE	PHONE NUMBER ()
SIGNATURE		DATE

**Please return the completed form to the employee
 or mail/fax to:
 Minnesota Dept. of Human Services
 P.O. Box 64972
 St. Paul, MN 55164-0972
 FAX: 651-431-7414**

651-431-2414 or 800-657-3761 (toll free)

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለዎንም ከፍያ ይህንን ደብዳቤ ለማረጋገጥ የሚተረጎሙ ለሰጠዎት ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

ຄំណត់ສໍາຄານ 1 ။ မျှော်မှတ်ထားသည့်အထောက်အကူပေးခြင်းအတွက် အထက်ဖော်ပြပါဖုန်းနံပါတ်ကို ခေါ်ဆိုပါ။

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyccm. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သုဉ်ဟ်သးဘဉ်တက့ၢ်. ဝဲန့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလီၤလၢတၢ်ကကျိးထံဝဲဒၣ်လၢ် တီလၢ်မိတခါအံၤန့ၢ်, ကိးဘဉ်လိတဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ၢ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (8-16)

ADA1 (2-18)



For accessible formats of this publication or additional equal access to human services, write to DHS.info@state.mn.us, call 651-431-4300 or 866-267-7655 (toll free) or use your preferred relay service. .