NYC Human Resources Administration Department of Social Services
Family Independence Administration

Date: _____

Case Number: _____

Case Name: _____

Notice to Applicants and Participants Regarding Third Party Health Insurance

As a condition of eligibility, Cash Assistance applicants and participants are required to apply for and use any group health insurance available to them. This insurance coverage can be provided by their present or former employer or union plan, coverage provided under a legally responsible relative's plan or any other source.

You are required to provide information concerning health insurance coverage for yourself and other legally responsible relatives who are eligible for group health insurance. Please have the appropriate person (current/former employer, union representative or other party offering group health insurance) complete the reverse of this form and return it to you. If you have been instructed to mail it, send it to the address provided. If you are scheduled for an interview, bring the completed form with you along with any health, dental, optical and/or prescription drug identification cards that have been issued to you.

If you refuse or fail to cooperate in the verification of this information, or refuse to apply for any group health insurance available to you, your Cash Assistance and Medicaid may be denied or terminated in accordance with NYCRR 351.1(b)(2)(iii).

Include in 'A' Kit/Recert Packet

Applicant's/Participant's Name: _____ **Case Number:** _____

Health Insurance for: _____
(Current/Former Employee)

Date Employment Began : _____ **Date Employment Ended:** _____

Home address while in your employ: _____

_____

City: _____ State: _____ Zip: _____

Social Security number under which payments were made: _____

Does employee have health insurance? ☐ **Yes** ☐ **No**

Through Employer: _____ Through Union: _____

Name of Carrier: _____ Group Number: _____

Policy or ID Number: _____ Coverage Dates: From _____
To _____

Names of Covered Individuals: _____

Amount Paid by Employee: $_____ per _____
(Week/Month)

Types of Coverage Enter "x" in applicable coverage code(s):	MJR MED	INP HOS	SENR CARE	OUT PAT	DRG PHM	HOME CARE	DENTAL	NURS HOME	OPTICAL
	☐	☐	☐	☐	☐	☐	☐	☐	☐

If no longer in your employ, is health insurance coverage still available? ☐ Yes ☐ No

Can policy be converted to an individual policy? ☐ Yes ☐ No

Cost of conversion to employee: $_____ per _____ .
(Week/Month)

Employer Information

Address: _____

_____

City: _____ State: _____ Zip: _____

Employer ID No.: _____

Please print your name: _____

Signature: _____

Title: _____