HEALTHCARE REFORM DATA COLLECTION eFORM

This form needs to be completed by Employees with a Spouse/Domestic Partner and/or Dependent enrolled in plan coverage.

SECTION A: EMPLOYEE INFORMATION

Employee Name: *Last (Suffix), First Middle*	Gender: Select Gender	Employee Soc. Sec. Number	Employee Date of Birth:

Employee Address

(Street Address)	*(City)*	*(State)*	*(Zip)*	Telephone No.

SECTION B: SPOUSE/DOMESTIC PARTNER (S/DP)SECTION

S/DP Name: *Last (Suffix), First Middle*	S/DP Gender: Select Gender	File Joint Federal Taxes? Enter Response	S/DP Date of Birth:

Spouse/DP Social Security Number:

S/DP Insurance Coverage

Legally Married? ☐ Yes ☐ No	Is S/DP Employed Full Time? ☐ Yes ☐ No	Is S/DP eligible for own Employer Coverage? ☐ Yes ☐ No
Is S/DP Enrolled in Other Coverage? ☐ Yes ☐ No	If yes, identify type of other health coverage below: ☐	

SECTION C: DEPENDENT DATA

Child Name: *Last (Suffix), First Middle*	Child Gender: Select Gender	Is Child Tax Dependent? No	Child Date of Birth:

Child's Social Security Number:

Child's Relationship to Employee: ☐ Son ☐ Daughter ☐ DP Child ☐ Grandchild ☐ Other (specify):

Child Insurance Coverage

Is Child Employed? ☐ Yes ☐ No	If yes, is Child eligible for Employer Coverage? ☐ Yes ☐ No
Is Child **Enrolled** in Other Coverage? ☐ Yes ☐ No	If yes, check here and identify type of other health coverage below: ☐

Child Name: *Last (Suffix), First Middle*	Child Gender: Select Gender	Is Child Tax Dependent?: No	Child Date of Birth:

Child's Social Security Number:

Child's Relationship to Employee: ☐ Son ☐ Daughter ☐ DP Child ☐ Grandchild ☐ Other (specify):

Child Insurance Coverage

Is Child Employed? ☐ Yes ☐ No	If yes, is Child eligible for Employer Coverage? ☐ Yes ☐ No
Is Child **Enrolled** in Other Coverage? ☐ Yes ☐ No	If yes, check here and identify type of other health coverage below: ☐

SECTION D: MEDICARE INFORMATION

Do you or any of your dependents have Medicare? ☐ Yes ☐ No

If yes, please complete the following for each Medicare covered person: *Check applicable Medicare coverage(s) and employment status:*

Name of Covered Person:	Part A	Part B	Part D	Employed	Retired	Disabled	ESRD

I hereby certify that the above statements are complete and accurate to the best of my knowledge.

Employee Signature: _____ Date: _____

HEALTHCARE REFORM DATA COLLECTION eFORM

This form needs to be completed by Employees with a Spouse/Domestic Partner and/or Dependent enrolled in plan coverage.

SECTION C: DEPENDENT DATA (CONTINUED)

Child Name: *Last (Suffix), First Middle*	Child Gender: Select Gender	Is Child Tax Dependent? No	Child Date of Birth:
Child's Social Security Number:			
Child's Relationship to Employee: ☐ Son ☐ Daughter ☐ DP Child ☐ Grandchild ☐ Other (specify):			
Child Insurance Coverage			
Is Child Employed? ☐ Yes ☐ No	If yes, is Child eligible for Employer Coverage? ☐ Yes ☐ No		
Is Child **Enrolled** in Other Coverage? ☐ Yes ☐ No	If yes, identify type of other health coverage below: ☐		

Child Name: *Last (Suffix), First Middle*	Child Gender: Select Gender	Is Child Tax Dependent? No	Child Date of Birth:
Child's Social Security Number:			
Child's Relationship to Employee: ☐ Son ☐ Daughter ☐ DP Child ☐ Grandchild ☐ Other (specify):			
Child Insurance Coverage			
Is Child Employed? ☐ Yes ☐ No	If yes, is Child eligible for Employer Coverage? ☐ Yes ☐ No		
Is Child **Enrolled** in Other Coverage? ☐ Yes ☐ No	If yes, identify type of other health coverage below: ☐		