Application for Health Coverage Subsidy

Employee Name: ___________________________University ID Number: _____________

Department: ____________________________ Daytime Phone #: _________________

Email address: ________________________________ Subsidy Year: 2017

Number of persons in Household: _________ (Including you)

All questions below must be answered, or the subsidy application will be returned.

Name _________________________ Date of Birth ________________ Relationship ______Worked in 2015? ____

Name _________________________ Date of Birth _________________ Relationship ______Worked in 2015? ____

Name _________________________ Date of Birth _________________ Relationship ______Worked in 2015? ____

Name _________________________ Date of Birth _________________ Relationship ______ Worked in 2015? ____

Name _________________________ Date of Birth _________________ Relationship ______Worked in 2015? ____

Certification and Signature: With this application, I am applying for a subsidy for health coverage rates due to my household income. I understand that if I am approved for the subsidy, it will be effective as of January 1 of the year listed above and will terminate on December 31 of that same year, or an earlier date if I:

- Leave employment prior to December 31,
- Have a change in family status that impacts my eligibility, or
- Am no longer eligible for medical coverage (COBRA coverage will apply at the standard COBRA rates).

I understand that if this form is not fully completed, my application will be returned. My subsidy application will not be considered until all questions are answered. Indiana State University has the right to modify or terminate this policy at any time. Additionally, I understand that this form must be submitted each year for which the subsidy is requested.

The application is not complete until all blanks are answered and Staff Benefits has received the Tax Return Transcript.

____ ____

Signature **Date**

Staff Benefits Information Only: **Year of Subsidy Application: _________________**

Number in household: _______ Total Household Income: __________________________

Federal Tax Subsidy @ 200%: ________________

Approved **Denied** **Reason: ____**