INSTRUCTIONS FOR HEALTH CARE INSURER
NOTIFICATION OF HEALTH INSURANCE COVERAGE

IMPORTANT NOTE: This form must be filed with the Arizona Department of Revenue by the 15th day of the month following the month in which health insurance coverage commences. All applicants for a given month can be listed on one form.

HEALTH CARE INSURER NAME:

Please print the name of the health care insurance company that will be providing health insurance to the applicants listed on the bottom of the form.

HEALTH CARE INSURER ADDRESS NUMBER AND STREET OR PO BOX:

Please print the complete mailing address of the health care insurance company as it would appear on your Arizona Health Insurance Premium Tax Return.

CONTACT PERSON NAME AND PHONE NUMBER:

Please print the name and phone number of the person that will be signing the application and that may be contacted if the Department of Revenue has questions regarding the information on the Notification of Health Insurance.

NAIC # and Federal Identification #:

Please write the NAIC number and the Federal Identification number as they would appear on your Arizona Health Insurance Premium Tax Return.

INSTRUCTIONS FOR THE NOTIFICATION OF HEALTH INSURANCE COVERAGE TABLE

COLUMN (a) INSURED NAME:

Please print the name of each individual or small business insured in the month for which this NOTIFICATION is being submitted. The name shown in this column should match that shown on the Certificate of Eligibility.

COLUMN (b) CERTIFICATE NUMBER:

Please write the Certificate Number from the Certificate of Eligibility for each individual or small business.

COLUMN (c) DATE INSURANCE COVERAGE WAS APPLIED FOR:

Please write the date on which the individual or small business applied for health insurance coverage.

COLUMN (d) DATE INSURANCE COVERAGE WAS OBTAINED:

Please write the date on which insurance coverage was approved and issued for the applicant. Insurance coverage must be obtained by the date indicated on the Certificate of Eligibility but insurance coverage does not have to commence by this date.

COLUMN (e) DATE INSURANCE COVERAGE COMMENCED:

Please write the date on which health insurance coverage commenced for the individual or small business. Each NOTIFICATION submitted should only list applicants for which insurance coverage commenced in the same month.

COLUMN (f) COVERAGE RECEIVED:

*This column should reflect the **actual coverage** that the applicant received.*

For an individual, the coverage would be: (1) "applicant" indicating that only the applicant is receiving health insurance coverage, (2) "X dependent(s)" indicating that coverage is for the applicant's dependent(s) only (X being the number of dependents), or (3) "family" indicating that the entire family is being covered.

For a small business, the coverage would be "X single, X family" with X being the actual number of employees enrolled with single or family coverage. For example, the small business may enroll 5 employees with single coverage and 3 employees with family coverage (even if the Certificate of Eligibility was based on a higher number of 10 employees seeking single coverage and 6 employees seeking family coverage). The Notification of Coverage should reflect the actual enrollment of "5 single" and "3 family."

COLUMN (g) STATUTORY CREDIT ALLOWANCE

This column is a calculation that equals the actual coverage received indicated in Column (f) times the statutory allowances. The statutory allowances are as follows.

For an individual:

"Applicant" is equal to a credit allowance of $1,000.

"X dependents" is equal to a credit of $500 for each dependent.

"Family" is equal to a credit of $3,000.

For a small business:

"X single" (where X is a number) is equal to a credit allowance of $1,000 for each employee electing single coverage.

"X family" (where X is a number) is equal to a credit allowance of $3,000 for each employee electing family coverage.

*If the actual coverage received is different than the number of employees seeking coverage according to the basis for the value of the Certificate of Eligibility, the statutory credit allowance **must be recalculated**. However, the statutory credit allowance cannot exceed the amount shown on the Certificate of Eligibility.*

COLUMN (h) 50% OF ANNUAL HEALTH INSURANCE PREMIUM:

Please write the dollar amount that is equal to 50% of the individual's or small business' annual health insurance premium.

COLUMN (i) ALLOWABLE CREDIT:

Please write the allowable health insurance premium tax credit for this particular individual or small business. This should be the lesser of column (g) or column (h).

This Notification must be signed by the health care insurance company contact person and dated. Failure to complete the form in full may affect the amount of insurance premium tax credit which the health insurance company may claim.

If you have questions regarding this form, call Darlene Teller at (602) 716-6436. Submit the completed form or a replica of the form as produced on your own system, to:

Georganna Meyer, Chief Economist or Darlene Teller, Economist
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