

State of Hawaii
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division/Eligibility Branch

TO: _____

DATE: _____
FROM: _____
TELEPHONE #: _____
(Between 9:00 a.m. to 3:00 p.m.)

Name of Employee: _____

The Department is requesting additional information regarding health insurance coverage to employees. Employed persons who are eligible for employer-sponsored health insurance are not eligible to participate in the Hawaii QUEST program. The Department is requesting that you provide verification that health insurance is available or not available to you. If you are asking your employer to furnish this information, please have your employer complete and sign this form.

Please provide this information by: _____.

1. Is health insurance available? Yes No
2. If health insurance is NOT AVAILABLE, please state reasons why the employee is not eligible for the insurance.

Signature of Employer/Title

Date

Name of Company/Organization

Telephone