

Affordable Care Act (ACA) Notification Checklist

California Department of Human Resources State of California

This Checklist is intended to document and ensure that departments/agencies are providing the legally required notices to employees for compliance with the ACA. Parts I and II must be completed, if applicable.

PART I documents the distribution of the Health Insurance Marketplace Coverage Options and Health Coverage Notice to newly hired employees (e.g., new to the state, department, or agency).

PART II documents the distribution of the Summary of Benefits and Coverage Notice and the Health Benefits Plan Enrollment form to employees newly eligible for health benefits.

Upon completion, this Checklist must lemployee Information	be retained in the employee's Off	cial Personnel File.	
Employee Name		Hire Date	
Position Number	Social Security Number	Tenure/Time Base	
☐ New State Employee			
If employee is appointed to a position elig health benefits, complete Part I only.	ible for health benefits, complete Pa	arts I and II. If employee is not eligible for	
☐ Current State Employee who is New	ly Hired at Department/Agency Ol	R Newly Eligible for Health Benefits	
If employee is not eligible for health benef Part I only. If employee has been appointed Temporary/Intermittent to Permanent/Full	ed to a position that makes them ne	wly eligible for health benefits (e.g.,	
Part I - New Employees			
The Health Insurance Marketplace Coverance employee in your department/agency	•	Notice is required to be provided to every	
Date Provided	Department Representative	Э	
Part II - Employees Newly Eligible	for Health Benefits		
The following health benefit documents st day the employee is eligible to enroll in co be provided to employee no later than Se	overage (e.g., employee is hired on	August 12, the following documents must	
☐ Summary of Benefits and Coverage	age Notice		
☐ Health Benefits Plan Enrollment	Form (HBD-12)		
Date Provided	Department Representat	Department Representative	
Human Resources Office use Only	/		
I certify that data stated herein is correct,	complete, and in accordance with a	ll laws and regulations.	
Department/Agency Name		Contact Number	
HR Representative Printed Name	HR Representative Signatur	e Date	