Job Update

This form is used to tell MassHealth about a new job or a change in your job.

Please enter your name and social security number (SSN) or MassHealth ID directly below. You must complete all sections. Sign and date the form.

Employee Name _____ Employee SSN/MassHealth ID _____

Section A. Current Job Information (You must complete this section.)

☐ **I am currently working (fill out the following section(s))**

1. Current Job 1

Name of employer _____

Address of employer _____

a. Wages/tips (before taxes) $_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly
(Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)

b. How many hours a week do you work? _____

c. Are you seasonally employed? ☐ yes ☐ no
If yes, how many months do you work each calendar year? _____

d. Are you self-employed? ☐ yes ☐ no

e. If yes, how much net income (profits after business expenses are paid) will you get from this self-employment each month?
$_____

f. Is this job a sheltered workshop? ☐ yes ☐ no

g. Is health insurance offered that would cover doctors' visits and hospitalizations? (Answer **yes** even if you cannot get it now, chose not to sign up for it, or dropped insurance that was available.) ☐ yes ☐ no
If you answered **no** to the last question, was health insurance offered in the last six months? ☐ yes ☐ no

2. Current Job 2 (If you have more jobs and need more space, attach another sheet of paper.)

Name of employer _____

Address of employer _____

a. Wages/tips (before taxes) $_____ ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly
(Subtract any pre-tax deductions, such as non-taxable health insurance premiums.)

b. How many hours a week do you work? _____

c. Are you seasonally employed? ☐ yes ☐ no
If yes, how many months do you work each calendar year? _____

d. Are you self-employed? ☐ yes ☐ no

e. If yes, how much net income (profits after business expenses are paid) will you get from this self-employment each month?
$_____

f. Is this job a sheltered workshop? ☐ yes ☐ no

g. Is health insurance offered that would cover doctors' visits and hospitalizations? (Answer **yes** even if you cannot get it now, chose not to sign up for it, or dropped insurance that was available.) ☐ yes ☐ no
If you answered **no** to the last question, was health insurance offered in the last six months? ☐ yes ☐ no

You must send us two recent pay stubs or other proof of income along with this filled-out and signed form, OR your family's MassHealth or Health Safety Net (HSN) benefits will stop.

☐ **I recently stopped working (within the last six months).**
When did you stop working? _____

☐ **I am receiving unemployment benefits. Send a copy of a recent check showing gross unemployment income.**

☐ **I have not worked within the last six months.**

Employee Name _____ Employee SSN/MassHealth ID _____

Section B. Yearly Income Information (You must complete this section.)

1. What is your total expected income for the current calendar year? $_____
2. What is your total expected income for next calendar year, if different? $_____

Section C. Health Insurance (You must complete this section.)

1. Are you and/or members of your family currently enrolled in health insurance from your job? ☐ yes ☐ no
   If yes, please fill out the section below and **send us a copy of both sides of the health insurance card(s).**
   a. Insurance company name _____
   b. Names of covered family members _____
   _____
   c. Policy number _____
   d. Is this COBRA coverage? ☐ yes ☐ no
   e. Is this a retiree health plan? ☐ yes ☐ no

Section D. Signature (You must complete this section.)

I certify under the pains and penalty of perjury that what is stated on this form is correct and complete to the best of my knowledge.

_____ _____

Signature of working person or authorized representative Date

Return this completed, signed form and proof of current income to

Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780