

Mississippi Department of Finance Administration
ACA Agency Contact Form and Questionnaire

OVERVIEW:

All agencies must review and submit this form no later than 4pm on October 24, 2023. Your agency has agreed to participate in the DFA filing process for ACA. As part of the process, DFA requires two agency contacts to ensure effective communication regarding deadlines, submissions, and resolution of issues. Additionally, these contacts will act as signing authority for your agency by approving your completed ACA forms prior to both remittance to employees and IRS submission.

We understand **our agency is responsible** for reviewing, validating and providing all information requested by DFA or our third-party Gallagher/MZQ by deadlines provided.

Please identify two ACA contacts for file remittance and deadline confirmation. Agencies must ensure contacts will be available for file submission and issue resolution prior to deadlines beginning in October 2023 through March 2024 for the 2023 filing year.

Agency ACA Contact One:

Name: _____ E-mail: _____ Phone: _____

Agency ACA Contact Two:

Name: _____ E-mail: _____ Phone: _____

OFFER OF COVERAGE FOR CONTRACT WORKERS:

Does your agency offer a health insurance plan to agency contract workers (also called WINs)?

Please select one of the following:

___ YES, our agency has a health insurance plan that was offered to our full-time contract workers (WIN) during the current Reporting Year 2023.

OR

___ NO, our agency did not offer a health insurance plan to our full-time contract workers (WIN) during the current Reporting Year 2023.

If you answered "YES" please complete Page 2 "Questionnaire for Contract Worker Coverage". If you need assistance answering these questions, please contact your third-party insurance provider. If further clarification is needed, please contact both Thomas Rivenbark thomas@mzqconsulting.com and Angela Tyler angela.tyler@dfa.ms.gov with the subject "SOMS – QUESTIONNAIRE CONTRACT WORKER COVERAGE".

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QUESTIONNAIRE FOR CONTRACT WORKER COVERAGE:

<i>Agency Insurance Offer</i>	
Was the plan fully insured or self-insured?	
<i>Plan Details</i>	
When does the plan year start?	
<i>Offers of Coverage</i>	
Does the plan offer coverage to the spouses of eligible employees?	
Can all spouses participate, or only ones who do not receive an offer of coverage through their employers?	
Does the plan offer coverage to the dependents of eligible employees?	
<i>Waiting Period</i>	
Do all new FTEs wait the same amount of time before they can participate in that medical plan?	
Please list the waiting period for each FTE or group of FTEs in an attachment to this form.	
Did the waiting period(s) change at your renewal or mid-year new plan implementation? If yes, please list the new termination period in an attachment to this form.	
Do all terminated FTEs lose eligibility in the medical at the same time?	
Please list the termination period for each FTE or group of FTEs in an attachment to this form.	
Did the termination period(s) change at your renewal or mid-year new plan implementation? If yes, please list the new termination period in an attachment to this form.	
<i>Employee Contribution Information</i>	
Does everybody who elects self-only coverage on your least-expensive plan, pay the same monthly amount?	
Please list how much this employee contribution amount is for each FTE or group of FTEs in an attachment to this form.	
How much is this employee contribution amount after your renewal or mid-year new plan implementation?	

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All responses should be scanned and remitted by email to financialaffairs@dfa.ms.gov.

In signing this you are identifying your two agency's ACA Contacts as listed on Page 1 and granting them signing authority to approve ACA Forms and IRS Submissions. Agencies agree that one or both contacts will be available for file submission and issue resolution prior to deadlines beginning in October 2023 through March 2024 for the 2023 filing year. Additionally, agencies agree **our agency is responsible** for reviewing, validating and providing all information requested by DFA or our third-party Gallagher/MZQ by deadlines provided.

Agency Name (print or type your agency name)

SPAHRS Agency Number(s) (please separate multiple agency numbers with commas)

Accounting or HR Director (print name and title)

Accounting or HR Director (signature)

Date of Signature

For DFA Internal Use (Do not fill out):

Employer Legal Name:	
Employer Identification Number:	
Employer Legal Name:	
Employer Identification Number:	
Employer Legal Name:	
Employer Identification Number:	
Employer Legal Name:	
Employer Identification Number:	
Employer Legal Name:	
Employer Identification Number:	