Analyst: _____HIPP#_____

EMPLOYER INSURANCE VERIFICATION

Virginia Department of Medical Assistance Services
Health Insurance Premium Payment (HIPP)/HIPP For Kids
Program Application – Part 2
600 E. Broad Street, 12th Floor, Richmond, VA 23219
(804) 225-4236 / (800) 432-5924 (in Virginia only)

The Commonwealth of Virginia is considering providing the health insurance premium assistance on behalf of the employee below in accordance with Section 1906/1906A of the Social Security Act. Any information provided on the form will remain confidential. In order to make a determination, please complete and return this form within 15 days to the mailing address above. A HIPP analyst will be contacting the employer representative/insurance carrier to verify the information that has been provided on this form. The policy holder has authorized release of information, through the noted signature below, for verification of all required information. If you have questions in regards to completing the form, please contact us at the phone numbers listed above.

My signature serves as a release of information for verification of all required information.

Employee Name: _____ **Phone Number:**_____

Address: _____ **Signature:**_____**Date:**_____

INFORMATION BELOW IS TO BE COMPLETED BY THE EMPLOYER ONLY

If self-employed the policyholder must complete as the employer.

SECTION 1 – EMPLOYEE INFORMATION

Employee Name (Last, First, MI):	Full SSN: - -	(MM/DD/YY) Date of Birth: / /

1a. Employee Status ☐ Full-Time ☐ Part-Time ☐ Laid-Off

Date Hired: _____ 1b. Retiree? ☐ Yes ☐ No

1c. School Employee? ☐ Yes ☐ No

1d. If 1c answer is yes, check applicable box: ☐ 10-Month ☐ 12-Month

1c. Is this employee eligible for coverage under your company's group health plan? ☐ Yes ☐ No

(If "No", reason:_____)

1d. Is employee currently enrolled in the Health Plan? ☐ Yes ☐ No

If yes, provide the Effective Date:_____

SECTION 2 – MEMBERSHIP (Starting with Employee) - *Attach an additional page if more than 7*

Name (Last, First MI)	Full SSN	Date of Birth	Relationship	Currently Enrolled in Plan	Eligible for Health Plan
	- -	/ /	Employee	☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No

SECTION 3 - COVERAGE

3a. If the employee is currently enrolled, what is the type of coverage? Select one of the following:

☐ Employee Only ☐ Employee + Child ☐ Family
☐ Employee + Spouse ☐ Employee + Children ☐ Other_____
☐ COBRA

OPEN-ENROLLMENT INFORMATION

3b. Effective Date (MM/DD/YY): _____ /_____/_____

Open Enrollment Dates

From:_____ To:_____

3c. If the employee is not currently enrolled, when can enrollment occur?

☐ During Open Enrollment Dates: _____ ☐ After employment period is met - Date Eligible: _____
☐ Anytime

Analyst: _____HIPP#_____

SECTION 4 – PLAN BENEFITS (Please indicate the cost and benefits for the coverage you have selected.)

Employee Name(Last, First, MI):	Full SSN: - -
Name and Address of **Medical** Insurance Company: Insurance Company Phone: ( ) Insurance Policy/Group Number:	Name and Address of **Dental** Insurance Company: Insurance Company Phone: ( ) Insurance Policy/Group Number:
Does policy have a health savings account (HSA)? ☐ Yes ☐ No What are the annual deductibles for the health insurance: Individual $ Family $	Name and Address of **Vision** Insurance Company: Insurance Company Phone: ( ) Insurance Policy/Group Number:
Type of Health Plan **(Check all that apply):**	**Services Covered Under the Health Plan** **(Check all that apply):**
☐ Comprehensive Major Medical	☐ Medical
☐ HMO/PPO	☐ Pharmacy
☐ Hospital Only	☐ Vision
☐ Other	☐ Dental

Medical, Dental and Vision Insurance Premium Information.

Provide Employer & Employee costs for the elected plan(s):

Coverage Type	Medical Premium	Dental Premium	Vision Premium
Employee Only			
Cost to Employer	$ _____	$ _____	$ _____
Cost to Employee	$ _____	$ _____	$ _____
Employee + Spouse			
Cost to Employer	$ _____	$ _____	$ _____
Cost to Employee	$ _____	$ _____	$ _____
Employee + Child			
Cost to Employer	$ _____	$ _____	$ _____
Cost to Employee	$ _____	$ _____	$ _____
Employee + Children			
Cost to Employer	$ _____	$ _____	$ _____
Cost to Employee	$ _____	$ _____	$ _____
Family			
Cost to Employer	$ _____	$ _____	$ _____
Cost to Employee	$ _____	$ _____	$ _____

Frequency of Premium Payment Deductions
For Employee's elected plan(s)

Medical Premium	Dental Premium	Vision Premium
Weekly: ☐ 52 Weeks ☐ 50 Weeks ☐ 48 Weeks	**Weekly:** ☐ 52 Weeks ☐ 50 Weeks ☐ 48 Weeks	**Weekly:** ☐ 52 Weeks ☐ 50 Weeks ☐ 48 Weeks
Semi/Bi-Monthly: ☐ 24 pay periods ☐ 26 pay periods	**Semi/Bi-Monthly:** ☐ 24 pay periods ☐ 26 pay periods	**Semi/Bi-Monthly:** ☐ 24 pay periods ☐ 26 pay periods
Monthly: ☐ 10 Months ☐ 12-Months	**Monthly:** ☐ 10 Months ☐ 12-Months	**Monthly:** ☐ 10 Months ☐ 12-Months

SECTION 5 – EMPLOYER'S REPRESENTATIVE

Human Resource Representative or Benefits Manager:	Department:		
Employer/Company Name:	Work Phone: ( )		
Employer Address:	City:	State:	Zip Code:

Check the following box(es) that applies to your employer plan.

This medical plan ☐ qualifies ☐ does not qualify as credible coverage as a group health plan under section 270(c)(1) of the Public Health Service Act.

This medical plan ☐ is ☐ is not offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

I certify all information contained herein is true and accurate to the best of my knowledge.

Employer Signature: **Date:**