INSTRUCTIONS FOR COMPLETING THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) APPLICATION - PART 1 OF 2

Instructions: Please print and answer all of the questions, then sign and date the HIPP Program Application – Part 1. Attach a copy (front and back) of all health insurance cards (Medical, Dental & Pharmacy), copy of your latest pay stub and a copy of the Summary of Benefits (this is a summary of what is covered under the insurance plan) to your HIPP Program Application - Part 1, along with a completed Employer Insurance Verification Form – Part 2. Mail all documents to the HIPP Unit address listed below.

Section 1 – Personal Information

Provide the Employee's full name, telephone numbers to include the area code, complete street address and mailing address (if different), city, state, zip code. If a home, work or cellular number is not available, please include an alternate number where a message can be left.

If the enrollee's address is different from the policyholder's, please provide complete street address, city, state and zip code.

Section 2 – Household Information

Starting with the employed person, list all household members including, but not limited to, parents, step-parents, guardians and children. Complete the date of birth in month/day/year format for each household member. Indicate the relationship of the person to the employed person by circling the corresponding number and relationship; i.e., 1 - Spouse, 2 – Parent/Step, 3 – Child, 4 –Step-child, 5 –Guardian, Other (specify).

Next, enter the nine-digit Social Security Number for each household member. Answer the remaining questions for each household member by placing a checkmark or an 'x' in the appropriate box.

Section 3 – Employer/Company Information

Indicate whether employment status is full or part-time and the date hired. If retired from previous employment, please indicate as well. Provide the employer or company name, street address, city, state and zip code, as well as the Human Resource Representative, or Benefits Manager's name and work phone number. If none, please provide a work phone number.

Indicate by placing a checkmark or an 'x' in the appropriate box, if the Policyholder's health insurance is covered under an Employer Sponsored plan, COBRA, or Individual Policy. If the Individual Policy box is selected, indicate whether the Policyholder is self-employed.

Indicate whether the health insurance premium is taken from the Policyholder's paycheck weekly, every two weeks, 24 times a year, 26 times a year, semi-monthly or monthly. If none of the choices apply, please select 'not applicable'. Indicate the amount taken from each pay period**.**

Indicate whether the Policyholder is able to enroll Medicaid eligible household members not currently enrolled under the employer or COBRA plan. Enter the earliest enrollment date in month/day/year format.

Please read the authorization section carefully and sign the HIPP Program Application - Part 1. Attach a copy (front and back) of all health insurance cards (Medical, Dental & Pharmacy), copy of your latest pay stub and a copy of the Summary of Benefits (this is a summary of what is covered under the insurance plan) to your HIPP Program Application – Part 1 and completed Employer Insurance Verification Form – Part 2. **Both the HIPP Program Application – Part 1 and Employer Insurance Verification Form – Part 2 must be received to be considered an application. The application date will be the date of when <u>both</u> forms are received by DMAS.** Mail all documents to the HIPP Unit address listed below.

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

Virginia Department of Medical Assistance Services
Health Insurance Premium Payment (HIPP) Program Application - Part 1 of 2

600 E. Broad Street, 12th Floor, Richmond, VA 23219
(804) 225-4236 / (800) 432-5924 (in Virginia only)

SECTION 1: PERSONAL INFORMATION

(Last, First, MI) Policyholder/Employee Name:

Home Phone ( )	Cell Phone ( )	Work Phone ( )	Alternate Phone: ( )

Street Address:	City	State	Zip Code
Mailing Address (if different):	City	State	Zip Code

PLEASE PROVIDE ENROLLEE'S ADDRESS IF DIFFERENT FROM POLICYHOLDER'S:
Street Address: City: State: Zip Code:

SECTION 2: HOUSEHOLD INFORMATION (PLEASE PRINT) - STARTING WITH THE POLICYHOLDER, LIST EVERYONE LIVING IN THE HOUSEHOLD

Name (Last, First MI)	Date of Birth (MM/DD/YY)	Relationship to Policyholder/Employee? 1 - Spouse 2 - Parent/Step 3 – Child 4 - Step-child 5 – Guardian Other (Specify)	Social Security Number	Does this person get Medicaid?	Does this person get Medicare?	Is this person covered under your insurance?
	/ /	Policyholder/Employee	- -	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	/ /	1 2 3 4 5 Other:____________	- -	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	/ /	1 2 3 4 5 Other:____________	- -	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	/ /	1 2 3 4 5 Other:____________	- -	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	/ /	1 2 3 4 5 Other:____________	- -	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	/ /	1 2 3 4 5 Other:____________	- -	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 3: EMPLOYER/COMPANY INFORMATION

Employee Status: ☐ Full-Time ☐ Part-Time Date Hired:________________________ Retired from previous employment? ☐ Yes ☐ No	Human Resources Representative or Benefits Manager:		Representative's Phone Number: ( )
Name of Employer/Company and Street Address:	City	State	Zip Code

Insurance Plan Type:
☐ Employer Plan ☐ COBRA ☐ Individual Policy ☐ None

If Individual Policy, is the Policyholder self employed?
☐ Yes ☐ No ☐ Not Applicable

How often do you pay the insurance premium? ☐ Weekly ☐ Every Two Weeks: ☐ 24/year, **or** ☐ 26/year
☐ Semi-Monthly ☐ Monthly Other: ______________________

Amount Each Pay Period:
$

Can you enroll Medicaid family members under your employer or COBRA health plan, if not currently enrolled?
☐ Yes ☐ No ☐ Not Applicable If yes, what is the earliest date (MM/DD/YY)?

AUTHORIZATION: "My signature below certifies under penalty of perjury that all declarations made in this application are true, accurate and complete, to the best of my knowledge. I authorize insurers or employers to release any information on myself, or other household member (s) necessary to determine eligibility for the HIPP Program."

Signature of Applicant	(MM/DD/YY) Date:

SECTION 4: HIPP SECTION ONLY

Medicaid Case ID #:	Medicaid Case Name:	HIPP #:	Court Ordered Absent Parent Case? ☐ Yes ☐ No	Analyst's Initials: