Analyst: _______HIPP#_____________

HEALTH INSURANCE PREMIUM PAYMENT PROGRAMS APPLICATION/RENEWAL FORM INSTRUCTIONS

Instructions: Please print and answer all of the questions, then sign and date the Health Insurance Premium payment Program Application/Renewal Form. 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 Application/Renewal, along with a completed Employer Insurance Verification Form. Send all documents to the HIPP Unit (see below).

Section 1 – Personal Information
Provide the Employee's full name, telephone numbers including 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, and 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 Health Insurance Premium Payment Program Application/Renewal Form. 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 Health Insurance Premium Programs Application/Renewal Form and completed Employer Insurance Verification Form.

Both the Health Insurance Premium Payment Programs Application/Renewal Form and Employer Insurance Verification Form 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 address listed below, Fax to (804) 452-5447 or Email to HIPPcustomerservice@dmas.virginia.gov

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