Analyst: _____HIPP#_____

EMPLOYER INSURANCE VERIFICATION

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Health Insurance Premium Payment Programs Unit
600 E. Broad Street, Richmond, VA 23219
(804) 225-4236 / (800) 432-5924 (in Virginia only)
Fax Number: 804-452-5447
Email Address: HIPPCustomerService@dmas.virginia.gov

* 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.

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

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

1c. School Employee? ☐ Yes ☐ No

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

1e. 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
	- -	/ /	Employee	☐ 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:_____

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:

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

Employer Signature: **Date:**