

**This is a Change Form for the Health Insurance Premium Payment Program**

You are required to report all changes that occur in your employment, health insurance or household information. Please utilize the coupons below. A new HIPP Application and Employer Insurance Verification (EIV) Form is required for all asterisk (\*\*) items. **Note:** All changes must be reported within 10 calendar days of when the change is known.

Forms for the HIPP Program can be downloaded at: <http://www.dmas.virginia.gov/rcp-HIPP.htm>

**Name of Policyholder:** \_\_\_\_\_ **SSN#:** \_\_\_\_\_  
**Name of Medicaid eligible household member:** \_\_\_\_\_ **HIPP#:** \_\_\_\_\_

<b>Check</b> ✓	<b>**</b>	<b>NOTE:</b> Checkmark each item that you are reporting a change for. You are required to report all changes that occur in your employment, health insurance or household information. A new HIPP Application and Employer Insurance Verification (EIV) Form is required for all asterisk (**) items. <b>Note:</b> All changes must be reported within 10 calendar days of when the change is known. Failure to report changes may result in non-payment of HIPP premium assistance payments or cancellation from the program. Please use the coupons provided for reporting all changes.
		Employee's New Address & Phone Number:
	<b>**</b>	Employment Status:
	<b>**</b>	Name and Address of New Employer:
	<b>**</b>	Name and Address of New Insurance Company:
		Effective Date of New Insurance: <span style="float: right;">**Premium Amount:</span>
	<b>**</b>	Dependents added, canceled or dropped from policy:

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**Name of Policyholder:** \_\_\_\_\_ **SSN#:** \_\_\_\_\_  
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	<b>**</b>	Name and Address of New Insurance Company:
		Effective Date of New Insurance: <span style="float: right;">**Premium Amount:</span>
	<b>**</b>	Dependents added, canceled or dropped from policy:

**TAB – E**

**Name of Policyholder:** \_\_\_\_\_ **SSN#:** \_\_\_\_\_  
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