

Health Insurance Premium Payment Programs Application/Renewal Form

**Department of Medical Assistance Services
(804) 225-4236 / (800) 432-5924 (in Virginia only)**



SECTION 1: PERSONAL INFORMATION *All Sections Below To Be Completed By Employee*

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

Home Phone () ()	Cell Phone () ()	Work Phone () ()	Email Address:
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Street Address:	City	State	Zip Code
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Mailing Address (if different):	City	State	Zip Code
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PLEASE PROVIDE MEMBER'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	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /	1 2 3 4 5 Other: _____	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /	1 2 3 4 5 Other: _____	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /	1 2 3 4 5 Other: _____	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /	1 2 3 4 5 Other: _____	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /	1 2 3 4 5 Other: _____	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 3: EMPLOYER/COMPANY INFORMATION

Employee Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time Date Hired: _____ <input type="checkbox"/> Laid-Off	Human Resources Representative or Benefits Manager:	Representative's Phone Number: () ()
Retired from previous employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Name of Employer/Company and Street Address:	City	State	Zip Code
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Insurance Plan Type: <input type="checkbox"/> Employer Plan <input type="checkbox"/> COBRA <input type="checkbox"/> Individual Policy <input type="checkbox"/> None	If Individual Policy, is the Policyholder self employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
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How often do you pay the insurance premium? <input type="checkbox"/> Weekly <input type="checkbox"/> Every Two Weeks: <input type="checkbox"/> 24/year, or <input type="checkbox"/> 26/year <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly Other: _____	Amount Each Pay Period: \$
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Can you enroll Medicaid family members under your employer or COBRA health plan, if not currently enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable If yes, what is the earliest date (MM/DD/YY)?	Court Ordered Absent Parent Case? <input type="checkbox"/> Yes <input type="checkbox"/> No
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AUTHORIZATION: I have given true & accurate information to the best of my knowledge. I understand that if I have given false information, withhold information, or fail to report a change I may be breaking the law & could be prosecuted for perjury, larceny &/or welfare fraud. I authorize insurers or employers to release any information on myself, or other household member (s) necessary to determine eligibility for the HIPP/HIPP For Kids Program.

Signature of Applicant	(MM/DD/YY) Date:
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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 both forms are received by DMAS. Mail all documents to the address listed below, Fax to (804) 612-0020 or Email to HIPPcustomerservice@dmas.virginia.gov

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



EMPLOYER INSURANCE VERIFICATION
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Health Insurance Premium Payment Programs Unit
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. 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 <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Laid-Off Date Hired: _____	1b. Retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No	1c. Is this employee eligible for coverage under your company's group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", reason: _____)
1c. School Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	1d. If 1c answer is yes, check applicable box: <input type="checkbox"/> 10-Month <input type="checkbox"/> 12-Month	1d. Is employee currently enrolled in the Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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

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

OPEN-ENROLLMENT INFORMATION

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

Open Enrollment Dates

From: _____ To: _____

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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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):
<input type="checkbox"/> Comprehensive Major Medical	<input type="checkbox"/> Medical
<input type="checkbox"/> HMO/PPO	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Hospital Only	<input type="checkbox"/> Vision
<input type="checkbox"/> Other	<input type="checkbox"/> 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	<i>Frequency of Premium Payment Deductions For Employee's elected plan(s)</i>		
Employee Only Cost to Employer Cost to Employee	\$ _____ \$ _____	\$ _____ \$ _____	\$ _____ \$ _____	Medical Premium Weekly: <input type="checkbox"/> 52 Weeks <input type="checkbox"/> 50 Weeks <input type="checkbox"/> 48 Weeks Semi/Bi-Monthly: <input type="checkbox"/> 24 pay periods <input type="checkbox"/> 26 pay periods Monthly: <input type="checkbox"/> 10 Months <input type="checkbox"/> 12-Months	Dental Premium Weekly: <input type="checkbox"/> 52 Weeks <input type="checkbox"/> 50 Weeks <input type="checkbox"/> 48 Weeks Semi/Bi-Monthly: <input type="checkbox"/> 24 pay periods <input type="checkbox"/> 26 pay periods Monthly: <input type="checkbox"/> 10 Months <input type="checkbox"/> 12-Months	Vision Premium Weekly: <input type="checkbox"/> 52 Weeks <input type="checkbox"/> 50 Weeks <input type="checkbox"/> 48 Weeks Semi/Bi-Monthly: <input type="checkbox"/> 24 pay periods <input type="checkbox"/> 26 pay periods Monthly: <input type="checkbox"/> 10 Months <input type="checkbox"/> 12-Months
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	\$ _____ \$ _____	\$ _____ \$ _____	\$ _____ \$ _____			

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 box that applies to your employer plan: **Yes** this plan meets **No** this plan does not meet, **both requirements.**

- Qualifies as creditable coverage, group health plan under section 270(c)(1) of the Public Health Service Act, and
- is offered to all individuals in a manner 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:** _____

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