Analyst: _______HIPP#_____________

Health Insurance Premium Payment Programs Application/Renewal Form

Department of Medical Assistance Services
(804) 225-4236 / (800) 432-5924 (in Virginia only)
Fax Number: 804-452-5447
Email Address: HIPPCustomerService@dmas.virginia.gov

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

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	- -	☐ 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:
$

AUTHORIZATION: I have given true & accurate information to the best of my knowledge. I understand that if I have given false information, withheld information, or failed to report a change I may be breaking the law & could be prosecuted. 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:

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)

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:**