HIPP #________________ Analyst____________

Health Insurance Premium Payment Programs Application/Renewal Form

Department of Medical Assistance Services
(804) 225-4236 / (800) 432-5924 (in Virginia only)
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 ( )	Alternate Phone: ( )
Street Address:	City	State	Zip Code
Mailing Address (if different):	City	State	Zip Code

PLEASE PROVIDE MEDICAID 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 ☐ Laid-Off Date Hired/Laid-off:____________ Retired from previous employment? ☐ Yes ☐ No Deceased? ☐ 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:** ☐52, ☐50 or 48 wks/yr ☐ **Every Two Weeks:** ☐ 24 **or** ☐ 26/yr ☐ **Semi-Monthly** ☐ **Monthly** **Other:** ____________

Amount Each Pay Period:
$

Can you enroll Medicaid family members under your employer or COBRA health plan, if not currently enrolled? ☐ Yes ☐ No ☐ Not Applicable **If yes**, what is the earliest date?

Court Ordered Absent Parent Case?
☐ Yes ☐ No

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 Programs.

Applicant Signature:	**Date:**
HIPP Case Number:________________ **(required)**	

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 most recent 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 signed by your employer. Send all documents to the DMAS HIPP Unit (see below).

Section 1 – Personal Information
Provide the Policy Holder'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 member's address is different from the policyholder's, please provide complete street address, city, state and zip code.

Section 2 – Household Information
Starting with the employed person, list all individuals living in the household 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, retired or laid-off. 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;
  - note if the Individual Policy box is selected, indicate if policyholder is self- employed; or
- if the coverage was court ordered to be carried by an absent/non-custodial parent.

Indicate whether the health insurance premium is deducted from the Policyholder's paycheck weekly, every two weeks, 24 times a year, 26 times a year, semi-monthly or monthly, etcetera. If none of the choices apply, please select 'not applicable'. Indicate the amount taken from each pay period**.**

Indicate if the policyholder is able to enroll <u>Medicaid eligible</u> 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, Vision & Prescription Drug (Pharmacy)), copy of your most recent 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 and signed 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 the application/renewal form is received at DMAS. Mail all documents to the address listed below, Fax to (804) 225-4393 or scan and email to HIPPcustomerservice@dmas.virginia.gov

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)

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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)
hippcustomerservice@dmas.virgnia.gov

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. Please complete, sign and return this form within 10 days to the address above. The policy holder has authorized release of information, through their signature below, for verification of all required information necessary for making a determination. If you have questions in regards to completing the form, please contact us at the phone numbers listed above.

My signature serves as permission for the release of information for verification of all required information for HIPP.

Employee Signature: ______________________________ **Phone#:**____________________ **Date:**______________

☐ Check box to grant permission for employer to email form to the Department of Medical Assistance Services.

INFORMATION BELOW IS TO BE COMPLETED BY THE EMPLOYER ONLY
If self-employed, policyholder must complete as the employer.

SECTION 1 – EMPLOYEE INFORMATION

Employee Name: (Last, First, MI):

Full SSN: - -

Date of Birth: / /

Employee Status ☐ Full-Time ☐ Part-Time ☐ Laid-Off ☐ Retiree ☐ Leave of Absence

Date Hired/Laid-off/Retired: ______________ **Deceased?** ☐ *Yes ☐ No

School Employee? ☐ *Yes ☐ No

***If yes, check box:** ☐ 10-Month ☐ 12-Month

Is this employee eligible for coverage under your company's group health plan? ☐ Yes ☐ No

If No, reason:____________________________________

Is employee currently enrolled in the Health Plan? ☐ *Yes ☐ No

***If yes, provide Effective Date:**__________________

SECTION 2 – MEMBERSHIP (Start 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	☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No
	- -	/ /		☐ Yes ☐ No	☐ Yes ☐ No

SECTION 3 - COVERAGE

If employee 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

Open Enrollment Period

From:____________________ To:___________________

Plan Year Begin Date:______________________________

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

☐ During Open Enrollment Dates: _______________________ ☐ After employment period is met-Date Eligible: _________________
☐ Anytime

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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:

Type of Health Plan (Check all that apply):

☐ Comprehensive Major Medical ☐ HMO/PPO
☐ Hospital Only ☐ Other

Does policy have a health savings account (HSA)? ☐ Yes ☐ No

Services Covered Under Health Plan (Check all that apply):

☐ Medical ☐ Pharmacy ☐ Vision
☐ Dental

Name and Address of **Dental** Insurance Company:

Insurance Company Phone: ( ) -
Insurance Policy/Group Number:

Name and Address of **Vision** Insurance Company:

Insurance Company Phone: ( ) -
Insurance Policy/Group Number:

Medical, Dental and Vision Insurance Premium Information. Provide Employer & Employee costs for the elected plan(s):

Coverage Type	Medical Premium	Medical Deduction Frequency	Dental Premium	Dental Deduction Frequency	Vision Premium	Vision Deduction Frequency
Employee Only Cost to Employer Cost to Employee	$ ______ $ ______	**Weekly:** ☐ 52 Weeks ☐ 50 Weeks ☐ 48 Weeks **Semi-Monthly:** ☐ 24 pay pd ☐ 26 pay pd ☐ 20 pay pd **Monthly:** ☐ 10 Months ☐ 12-Months	$ ______ $ ______	**Weekly:** ☐ 52 Weeks ☐ 50 Weeks ☐ 48 Weeks **Semi-Monthly:** ☐ 24 pay pd ☐ 26 pay pd ☐ 20 pay pd **Monthly:** ☐ 10 Months ☐ 12-Months	$ ______ $ ______	**Weekly:** ☐ 52 Weeks ☐ 50 Weeks ☐ 48 Weeks **Semi-Monthly:** ☐ 24 pay pd ☐ 26 pay pd ☐ 20 pay pd **Monthly:** ☐ 10 Months ☐ 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

HR Representative/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 below**.

- Qualifies as creditable coverage, group health plan under section 270(c)(1) of the Public Health Service Act; and
- **offered to all individuals (i.e. all employees)** 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: