TAB – E

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 family/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 family member:_____ _____**HIPP#:**_____

Check √	**	**NOTE:** 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 family/household information. 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. 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:
	**	Employment Status:
	**	Name and Address of New Employer:
	**	Name and Address of New Insurance Company:
		Effective Date of New Insurance: **Premium Amount:
	**	Family Members added, canceled, dropped from policy and/or change of address:

✂ cut here----------

Name of Policyholder:_____**SSN#:**_____
Name of Medicaid eligible family member:_____**HIPP#:**_____

Check √	**	**NOTE:** 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 family/household information. 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. 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:
	**	Employment Status:
	**	Name and Address of New Employer:
	**	Name and Address of New Insurance Company:
		Effective Date of New Insurance: **Premium Amount:
	**	Family Members added, canceled, dropped from policy and/or change of address:

TAB – E

Name of Policyholder:_____**SSN#:**_____
Name of Medicaid eligible family member:_____**HIPP#:**_____

Check √	**	**NOTE:** 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 family/household information. 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. 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:
	**	Employment Status:
	**	Name and Address of New Employer:
	**	Name and Address of New Insurance Company:
		Effective Date of New Insurance: **Premium Amount:
	**	Family Members added, canceled, dropped from policy and/or change of address:

✂cut here----------

Name of Policyholder:_____**SSN#:**_____
Name of Medicaid eligible family member:_____**HIPP#:**_____

Check √	**	**NOTE:** 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 family/household information. 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. 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:
	**	Employment Status:
	**	Name and Address of New Employer:
	**	Name and Address of New Insurance Company:
		Effective Date of New Insurance: **Premium Amount:
	**	Family Members added, canceled, dropped from policy and/or change of address: