

EMPLOYER INSURANCE VERIFICATION

Virginia Department of Medical Assistance Services
Health Insurance Premium Payment (HIPP) Program Application – Part 2
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 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. 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 Date Hired: _____	1b. Retired from previous employment? <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: _____) 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**OPEN-ENROLLMENT INFORMATION**

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

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

Open Enrollment Dates

From: _____ To: _____

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

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

SECTION 4 – PLAN BENEFITS (Please indicate the cost and benefits for the coverage you have selected.)

Employee Name (Last, First, MI):	Full SSN: - -
Medical/Health: Name and Address of Insurance Company:	Dental (if Applicable): Name and Address of Insurance Company:
Insurance Company Phone: ()	Insurance Company Phone: ()
Insurance Policy/Group Number:	Insurance Policy/Group Number:
Does policy have a health savings account (HSA)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision (if Applicable): Name and Address of Insurance Company:
What are the yearly deductibles for the health insurance: Individual \$ Family \$	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"/> Dental	<input type="checkbox"/> Dental
<input type="checkbox"/> High Deductible Health Plan	
<input type="checkbox"/> Other (please explain):	

Medical/Health, Dental and Vision Insurance Premium Information. (Employee's cost for the plans selected)

Coverage	Medical/ Health Premium	Dental Premium	Vision Premium	Medical/Health Premium	Dental Premium	Vision Premium
Employee Only	\$	\$	\$			
Employee + Spouse	\$	\$	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks: <input type="checkbox"/> 24/year <input type="checkbox"/> 26/year <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks: <input type="checkbox"/> 24/year <input type="checkbox"/> 26/year <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks: <input type="checkbox"/> 24/year <input type="checkbox"/> 26/year <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly
Employee + Child	\$	\$	\$			
Employee + Children	\$	\$	\$			
Family	\$	\$	\$	Other: _____	Other: _____	Other: _____
Other	\$	\$	\$			

SECTION 5 – EMPLOYER'S REPRESENTATIVE

Human Resource Representative or Benefits Manager:	Department:		
Employer/Company Name:	Work Phone: ()		
Employer Address:	City:	State:	Zip Code:
I hereby certify that all information contained herein is true and accurate to the best of my knowledge. Employer Signature:			Date: