GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor

Frank W. Berry, Commissioner

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CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)
EMPLOYER HEALTH INSURANCE DATA FORM – 2020 CASE REVIEW

Employee: _____ Social Security #: _____

Please provide the following information. See Page 2 for address, fax number, and email address.

1. Please attach a copy of the **2020** Benefit Rate Sheet to this form.
2. Name of plan the employee has chosen _____.
3. Number of employee pay periods for **2020** _____.
4. Number of times the premium will be deducted from employee's pay check in **2020**_____.
5. Amount of the premium you (**the employer**) are responsible for paying per pay period $_____. **(Please do not include a percentage)**
6. Amount of the premium the (**employee)** is responsible for paying (medical only) per pay period $_____. **(Please do not include a percentage)**
7. Start date and end date for open enrollment _____ through _____.
8. Effective date of changes made during open enrollment _____.
9. Name of insurance carrier(s) for your company's medical benefits _____.
10. Company Federal Employee Identification Number/Tax ID (FEIN): _____. (**Must be provided)**
11. Number of individuals employed by your company: _____.
12. Is your company a state employer? Yes / No
13. Does your company reside in the state of Georgia? Yes / No

Name/Address of Insurance Carrier ***Name/Address of Employer***

_____ _____
_____ _____
_____ _____
_____ _____

Insurance Carrier Phone Number: _____

_____ _____
Policy Number Group Number

_____ _____ _____
Completed By (Employer Signature) Date Phone Number

_____
Print Name/ Employer Title

Please return completed form to:

CHIPRA UNIT
900 Circle 75 Parkway
Suite 650
Atlanta, GA 30339
Fax: 855-777-0202
Email: chipra@hms.com