

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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APPLICATION FOR CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

Head of Household:		Referral Source:	
Address:		Address:	
City:	State:	City:	State:
Zip:	Telephone #	Zip:	Telephone #:

1. Complete the following information regarding your health insurance policy.

Policyholder's Name: _____ Insurance Co. Name: _____
 Policy Number: _____ Insurance Co. Address: _____
 Group Number: _____ City/State/Zip: _____
 Policyholder's Social Security Number: _____ Telephone #: _____
 Policyholder's Date of Birth: _____ Policyholder's Email: _____

2. Is the policy referenced in #1 the primary policy? YES _____ NO _____

3. Is there a secondary policy with another employer? YES _____ NO _____
 (If yes, please provide the information for the secondary policy on a separate page)

4. Complete the following information regarding the employer offering the policy referenced in #1.

Employer Name: _____ Employer Address: _____
 Employer Telephone: _____ City/State/Zip: _____

5. List all Medicaid eligible persons covered under this policy (use back of application for additional space).

NAME	SOCIAL SECURITY NUMBER	BIRTHDATE	MEDICAID ID #	RELATIONSHIP TO POLICYHOLDER	MALE/ FEMALE
1.		/ /			
2.		/ /			
3.		/ /			
4.		/ /			
5.		/ /			

6. Are any of these persons pregnant? Yes _____ NO _____

If yes:

Name	Expected Date of Delivery	Name	Expected Date of Delivery
_____	____/____/____	_____	____/____/____

7. Have any of the persons in #5 been diagnosed with a medical condition? If yes, please list all medical conditions or diagnosis (please provide a separate page if additional space is needed).

Name	Condition	NO
YES _____	_____	_____
_____	_____	_____

8. If known, how much are the premiums for this policy? \$ _____

9. How often is the premium amount paid?

☐ WEEKLY ☐ BIWEEKLY ☐ SEMIMONTHLY ☐ MONTHLY ☐ QUARTERLY ☐ OTHER

10. Complete the following information if COBRA benefits may be available from a former employer:

Have you received COBRA forms? YES _____ NO _____ Date COBRA forms received ____/____/____
 Last Date of Employment ____/____/____ (Please attach copy of COBRA enrollment packet to this application)

11. Can we contact your employer and/or insurance carrier to verify this information? YES _____ NO _____

12. Was applicant or any dependent injured at work or in an accident in the last 12 months? YES _____ NO _____ If yes,
 Attorney Name, if applicable: _____ Insurance Company, if applicable: _____

13. Please sign and date this application (TO BE SIGNED BY POLICYHOLDER ONLY).

 Policyholder's Signature

 Date