

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Gainwell Technologies/CHIPRA UNIT - 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084 Tel: (678) 564-1162, Option 2
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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).

<u>NAME</u>	<u>SOCIAL SECURITY NUMBER</u>	<u>BIRTHDATE</u>	<u>MEDICAID ID #</u>	<u>RELATIONSHIP TO POLICYHOLDER</u>	<u>MALE/ FEMALE</u>
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).

YES	Name	Condition	NO
_____	_____	_____	_____

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. Do you authorize the GA CHIPRA Unit to send communication via electronic mail to the policyholder's email address provided above? YES _____ NO _____

13. I certify under the penalty of perjury that all statements on or attached to this form are true and correct to the best of my knowledge.

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

 Policyholder's Signature Date