GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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2026 YEARLY REVIEW 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 people 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 people 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**
YES ____ **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**