



**HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM
EMPLOYER HEALTH INSURANCE DATA FORM**

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 **2022** Benefit Rate Sheet to this form.
2. Name of plan the employee has chosen _____.
3. Number of employee pay periods for **2022** _____.
4. Number of times the premium will be deducted from employee's paycheck in **2022** _____.
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



Employer Health Insurance Data Form
Page 2

Please return completed form to:

GAINWELL TECHNOLOGIES/HIPP UNIT

100 Crescent Centre Parkway

Suite 1000

Tucker, GA 30084

Phone: 678-564-1162, Option 1

Fax: 800-817-1769

Email: hippga@gainwelltechnologies.com (for attachments PDF format is preferred)

If you have any questions, please contact GAINWELL TECHNOLOGIES/HIPP Unit at 678-564-1162, Option 1.