### 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 **2023** Benefit Rate Sheet to this form.

2.        Name of plan the employee has chosen _____.

3.        Number of employee pay periods for **2023** _____.

4.        Number of times the premium will be deducted from employee's paycheck in **2023**_____.

5.        Amount of the premium you (**the employer**) are responsible for paying <u>per pay period</u> $_____.
         **(Please do not include a percentage)**

6.        Amount of the premium the (**employee**) is responsible for paying (medical only) <u>per pay period</u>
         $_____.  **(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

| **Brian P. Kemp, Governor** | **Russel Carlson, Commissioner** |
|---|---|

2 Martin Luther King Jr. Drive SE, East Tower   |   Atlanta, GA 30334   |   404-656-4507   |   www.dch.georgia.gov

Employer Health Insurance Data Form
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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.