GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Gainwell Technologies/HIPP UNIT – 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084 Tel: (678) 564-1162, Option 1
Fax: (800) 817-1769 Email: hippga@gainwelltechnologies.com

APPLICATION FOR HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

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**
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 HIPP 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**