

## Health Insurance Premium Payment Program Application

Please answer all of the questions and sign the application. If you have any questions or need help filling out this form, please call **515-974-3282** or **1-888-346-9562** (toll-free). We will be happy to help you!

Answer these questions about the person who has health insurance.

Policyholder	Home Phone (    ) Work Phone (    )
Street Address	City                      State                      Zip Code
Mailing Address (if different)	City                      State                      Zip Code

**Information about the health insurance company**

Name of Insurance Company	Policy Number
Street Address	City                      State                      Zip Code

**List all the people living in your home – Start with yourself**

Name (Last, First)	Birth Date Month/ Date/Year	Relationship to you?	Social Security Number	Does this person get Medicaid? Y/N	State ID number for Medicaid?	Does this person get Medicare? Y/N	Is this person currently covered by your insurance? Y/N
		Self					

Is this:  an **Individual Policy**    **COBRA** or    an **Employer Plan**? (Check one)

For **Employer Policies** or **COBRA**, list the name, city and state of employer: \_\_\_\_\_

How often do you pay the insurance premium? \_\_\_\_\_ How much? \$ \_\_\_\_\_

How do you pay your premiums? (Check one)

Payroll deduction    Check    Automatic withdrawal    Other: \_\_\_\_\_

What are the yearly deductibles for the health insurance:      Single \$ \_\_\_\_\_      Family \$ \_\_\_\_\_

If all Medicaid eligible people in your home are not currently enrolled in your employer policy or COBRA, can you or family members still enroll? If so, what is the earliest date? \_\_\_\_\_

Signature or Mark of Applicant	Date
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