



MISSOURI DEPARTMENT OF SOCIAL SERVICES

MO HEALTHNET DIVISION

APPLICATION FOR HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

<b>1. POLICYHOLDER INFORMATION</b>	<b>2. INSURANCE INFORMATION</b>
POLICYHOLDER NAME	INSURANCE NAME
POLICYHOLDER SOC. SEC. #	CLAIM MAILING ADDRESS
ADDRESS	INS. CITY, STATE, ZIP
CITY	INS. TELEPHONE
STATE, ZIP	POLICY NUMBER
TELEPHONE	POLICY GROUP NUMBER

3. Policy's lifetime dollar limit: \_\_\_\_\_ 4. Policy's cost cap per illness: \_\_\_\_\_  
 5. Amount of lifetime limit used to date: \_\_\_\_\_ 6. Policyholder's annual out-of-pocket limit: \_\_\_\_\_

7. LIST ALL PERSONS THAT CAN BE COVERED UNDER THE POLICY INCLUDING POLICYHOLDER

NAME	BIRTHDATE	MO HEALTHNET ELIGIBLE	MO HEALTHNET ID #	SOC. SEC. #
	/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> APP		
	/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> APP		
	/ /	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> APP		

8. Are you currently enrolled in this policy?  Yes  No  
 9. Are your dependents currently enrolled in this policy?  Yes  No  
 10. Are you currently:  Employed  Unemployed  On family or medical leave  
 11. Is this policy:  Through an employer  Through a former employer  Privately purchased  
 12. Are your premiums:  Payroll deducted  Paid directly to the insurance company  Paid directly to the employer  
 13. How much is your share of the premiums? \_\_\_\_\_  
 14. Premiums are paid:  Monthly  Biweekly  Semimonthly  Weekly  Quarterly  
 15. Next premium due date: \_\_\_\_\_  
 16. List employer or former employer's name, address and telephone number:

EMPLOYER NAME	EMPLOYER TELEPHONE
EMPLOYER ADDRESS	CITY STATE ZIP

**IMPORTANT**

YOU MUST PROVIDE A COPY OF THE INSURANCE POLICY BOOKLET, SUMMARY PLAN DESCRIPTION, EMPLOYEE HANDBOOK, ENROLLMENT MATERIALS, SCHEDULE OF BENEFITS OR SUMMARY OF COVERAGE THAT DESCRIBES THE POLICY. ELIGIBILITY FOR THE HIPP PROGRAM CANNOT BE ESTABLISHED WITHOUT THIS INFORMATION.

**My signature below guarantees that my answers on this form are correct, true and complete to the best of my knowledge. I authorize insurers or employers to release any information on myself or my dependent(s) needed to determine eligibility for the HIPP program.**

SIGNATURE OF POLICYHOLDER	DATE
SIGNATURE OF CARE COORDINATOR	TITLE
AGENCY/AFFILIATION	TELEPHONE DATE

Completed application with a copy of your policy information can be mailed to this address or given to your Division of Family Services caseworker to forward.

MO HealthNet Division  
ATTN: HIPP Program  
P.O. Box 6500  
Jefferson City, MO 65102-6500

## INSTRUCTIONS FOR COMPLETING THE APPLICATION

The Health Insurance Premium Payment (HIPP) Program pays for the cost of health insurance plans when the Department of Social Services decides it would cost less to buy health insurance to cover medical care than to pay for the care only with MO HealthNet funds. To be eligible for the Health Insurance Premium Payment (HIPP) program, some or all of the persons covered under an insurance policy must be eligible for MO HealthNet.

### WHO MUST APPLY?

You **must** apply to the HIPP program if all of the following are true:

- You or a member of your household is applying for MO HealthNet or are MO HealthNet-eligible (excluding spend-down)
- You or a member of your household is employed or lost employment within the last thirty days, and
- The employer or former employer offers **group** health insurance coverage.

If the Department of Social Services decides the health insurance plan is cost-effective, you **must** participate in the HIPP Program.

**Applicants', participants', parents', guardians' or caretakers' MO HealthNet benefits may be denied or canceled if the applicant, participant, parent, guardian or caretaker does not provide information necessary to establish cost effectiveness or does not enroll in a group health insurance plan that the Department determines is cost effective.**

### WHO CAN CHOOSE TO APPLY?

You can choose to apply to the HIPP program if you or a member of your household is applying for MO HealthNet or are MO HealthNet-eligible (excluding spend-down) and have health insurance available from sources **other than employers** (personal policies, credit unions, church affiliations, labor unions, memberships in organizations, etc.) If the Department determines the health insurance plan is cost effective, MO HealthNet will pay the premium.

- Section 1.** List the following information about the **policyholder**. Name, social security number, address, and telephone number. If you do not have a telephone, list a number where you can be reached or a message left.
- Section 2.** List the name, claim mailing address and telephone number of the insurance company, the policy number and the policy group number for any insurance you currently have or any insurance offered by your employer or some other source. If your employer or former employer **does not** offer group health insurance, write "no insurance available" across section 2, then sign and date the application.
- Questions 3 - 6.** Please try to provide as much information as you can obtain regarding the out-of-pocket cost, lifetime limits and caps per illness.
- Section 7.** List the name and birth date of everyone in your family who can be covered under this policy, including the policyholder. Check one box (Yes or No) to indicate whether the person is currently on MO HealthNet. If a box is marked yes, write the person's MO HealthNet identification number (DCN) listed on their MO HealthNet card. If they have applied for MO HealthNet and do not know if they are eligible, the APP (for Applied) box should be checked. List the social security number for each individual.
- Question 8.** Indicate whether you are currently covered by this insurance policy.
- Question 9.** Indicate whether your spouse or children are currently covered by this policy.
- Question 10.** Indicate your current employment status.
- Question 11.** Indicate if this insurance is through your current employer, a former employer (such as a COBRA plan), or an insurance plan you have purchased on your own.
- Question 12.** Indicate if your premiums are currently paid through payroll deduction, direct payment to the insurance company or direct payment to the employer.
- Question 13.** List how much the premium amount is each time a payment is due. If the insurance is through an employer and the employer pays for part of the cost, **list only your share of the cost.**
- Question 14.** List how often a premium payment is due. For example: monthly (once a month), biweekly (every two weeks), semimonthly (twice a month), weekly (once a week), quarterly (every three months).
- Question 15.** List the date your next premium is due.
- Section 16.** List your employer or former employer's name, address and telephone number. Employers are contacted to verify payroll deductions, rates, etc.
- Signature:** Sign and date the application form at the bottom.