



HEALTH INSURANCE PREMIUM PAYMENT PROGRAM APPLICATION



I. Eligibility Criteria

1. Are you currently receiving or eligible to receive employer-based health insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Are you currently enrolled in Medicare or Full-Scope (free) Medi-Cal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you currently enrolled in Medicare Part D?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Are you currently enrolled in a COBRA or Cal-COBRA policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a. If yes, when does it expire?		

II. Applicant Information

Applicant's Name (First, MI, Last)	Social Security Number		Mother's Maiden Name	
Home Address (Number, Street, Apt #)	City	County	State	Zip Code
Mailing Address (if different than home)	City	County	State	Zip Code
Telephone Number	Email Address		Date of Birth (mm/dd/yyyy)	

III. Demographic Information

1. Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Native Alaskan <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other
<input type="checkbox"/> Male <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Other _____
<input type="checkbox"/> Female <input type="checkbox"/> Transgender Female to Male

IV. Current Insurance Plan Information (Your most current billing statement must be included with this application)

Payee Name	Payee Contact Name	Payee Phone Number	
Payee Address (Number, Street, or P.O. Box)	City	State	Zip Code
Type of Policy (Individual, Small Group, Large Group)	Member ID/Policy Number	Monthly Premium Amount (\$)	

V. Please answer these questions ONLY if you obtained coverage through Covered California (otherwise leave blank)

1. What is your annual household income reported to Covered California?	Policy effective date:
2. What is your household size (Includes self, spouse, registered domestic partner, and/or dependent children)?	
3. How much of the monthly tax credit (APTC) are you eligible for?	How much will you be taking?
4. What type of plan did you enroll in?	<input type="checkbox"/> Bronze <input type="checkbox"/> Silver <input type="checkbox"/> Gold <input type="checkbox"/> Platinum

IMPORTANT: Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH). *Provision of the Social Security Number is voluntary. The information may be used to contact insurance companies, Consolidated Omnibus Budget Reconciliation Act (COBRA) administrators, employers and employer administered health insurance plans, enrollment workers, providers of health care services, and other governmental or public agencies as necessary to determine the extent of available health insurance and eligibility for insurance assistance and for the purpose of administering the program. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (844) 421-7050.

AUTHORIZATION: I authorize insurance companies, COBRA administrators, employers and employer administered health insurance plans, enrollment workers, providers of health care services, and other governmental or public agencies to release information to CDPH with regard to health insurance premiums, benefits and health care services provided to me. I authorize payment of refunds to CDPH for premiums paid by the program.

DECLARATION: I agree to re-enroll annually and re-certify as required by the HIPP Program. I certify that the answers I have given in this application and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance. I understand that it is my responsibility to immediately notify my Enrollment Worker of changes to my policy including: increases to my monthly premium; change in billing address; or enrolled in employer-based health insurance, Medicare, or Full-Scope (free) Medi-Cal.

Signature of Applicant

Date