ALABAMA HEALTH INSURANCE PREMIUM PAYMENT APPLICATION FORM

Please fill out questions 1-5 with applicant's personal information.

1. Name:	2. Social Security Number:
3. Address:	4. Area Code/ Phone Number:

5. ☐ **EMAIL** (Check box to sign up for email notifications.): Yes, once available, I choose to receive emails from HIPP that will include important information about the program and my payments. I understand that my email will not be used for anything other than HIPP correspondence. **Email Address:** _____

6. How did you hear about HIPP (choose an option below)?

☐ Mail	☐ Medicaid Caseworker	☐ Online search engine	☐ Health related support group	☐ Other:_____

7. Policyholder's Name:	8. Policyholder's Date of Birth:
9. Policyholder's Social Security Number:	10. Policy Number:
11. Insurance Carrier Name:	12. Policy Start Date:

13. Type of policy coverage (Check One): ☐ Individual ☐ Individual + Child(ren) ☐ Individual + Spouse ☐ Family

14. How are premiums paid (Check One)? ☐ Insured pays Insurance Carrier ☐ Insured pays Employer ☐ Payroll deduction

15. What type of health insurance do you have access to (Check One)? ☐ Employer ☐ Cobra ☐ Private ☐ Other ☐ None

Employer or COBRA insurance policyholders, please continue to question 16. Private or Other policyholders, please skip down to 21.

16. Open enrollment dates for health insurance obtained from employer? Start: ____/____/____ End: ____/____/____

17. Name of Employer:	18. Employer Telephone:	19. Employer Mailing Address:
20. Federal Employer Identification Number (FEIN):		

21. What is the premium for this policy (if known)? $ _____ These premiums are deducted/ paid:

☐ Weekly	☐ Every other week	☐ Twice a month	☐ Monthly	☐ Every three months	☐ Other

22 List everyone in your household covered by your policy, including Medicaid recipients. (Use extra paper if necessary.)

Name	Medicaid ID Number	Social Security Number	DOB	Medical Condition (Diabetes, asthma, etc)	Is this person pregnant?	Relationship to policyholder

Submitting "Medical Condition" is optional, although, listing this specific information may benefit the applicant.

23 ☐ **DIRECT DEPOSIT** (Check box to sign up for Direct Deposit)**:** If accepted onto the HIPP program, once this option is available, I would like to participate in the Direct Deposit program. By doing so, HIPP will deposit my payments into my checking account and I will not receive a paper check. If I am not accepted onto the program, HIPP will properly discard my banking information. **Bank Name:** _____ **Routing #:** _____

Checking Account #: _____ (Please provide a copy of your voided check with this application.)

24. ☐ **EMPLOYER CONTACT** (Check box if you agree.)**:** The HIPP program has permission to contact my employer to verify employer information that is necessary to process my HIPP application.

25. APPLICANT'S AGREEMENT: The information you provided will be used to determine your HIPP eligibility. By signing below, you are agreeing that the information provided on this form is true and complete to the best of your knowledge.

Signature: _____ **Date:** _____

Send your completed application to AL HIPP, 3066 Zelda Rd. Box 233 Montgomery, AL 36106, or fax it to 855-357-1130.
If you have any questions, call us toll-free phone at: 1-855-MyALHIPP.