

PO BOX 240756
Montgomery, AL 36124

FORM ONE: Alabama Health Insurance Premium Payment Application

Private policyholders: Complete FORM ONE and return it to the AL HIPP program. You may discard FORM TWO.

Employer-sponsored policyholders: : Complete FORM ONE and FORM TWO and return it to the Alabama HIPP program. FORM TWO should be completed by the policyholder's EMPLOYER, such as a Human Resource representative or Benefits Coordinator.

1. Do you or anyone in your family receive Medicaid Benefits? ☐ YES ☐ NO

2. Do you or anyone in your family have health insurance? ☐ YES ☐ NO

3a. **IF YES**, which type: ☐ EMPLOYER ☐ COBRA ☐ OTHER

3ai. What is the premium for this policy (if known)? \$_____ These premiums are paid/ deducted:

☐ Weekly	☐ Every other week	☐ Twice a month	☐ Monthly	☐ Quarterly	☐ Other
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3aii. Type of Coverage: ☐ Individual ☐ Individual and child ☐ Individual and Spouse ☐ Family

3b. **IF NO**, do you have access to health insurance, such as insurance benefits through your job? ☐ YES ☐ NO

Tell us as much as you can about the health insurance plan that you have access to. **If you do not have access to health insurance, you do not qualify for AL HIPP. Please safely discard your application forms. If you are not sure you qualify, feel free to call our toll-free number to speak with a HIPP eligibility advisor at.**

4. Please complete this section with the policyholder's information.

Name of Policy Holder: _____

Address: _____ City/ State/ Zip: _____

Home Phone: _____ Cell Phone: _____ Email(Required): _____

☐ Yes, HIPP can send information about the program and my payments to my email address provided above.

(Check box if this statement is true.)

SSN: _____ DOB: _____

Insurance Company: _____

Policy Number (Mandatory): _____ Group Number: _____

Effective Date of Policy: _____ End Date: _____ Other: _____



**AL
HIPP**

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FORM ONE (continued): Alabama Health Insurance Premium Payment Application

5. List all persons covered by the policy who are eligible for Medicaid. (Use extra paper if you need to.)

Name	Social Security Number	Birth Date	Medicaid ID Number	Relationship to Policyholder	Gender	Condition
		/ /				
		/ /				
		/ /				
		/ /				

6. From what source did you receive this application (choose an option below)?

☐ Mail	☐ County Caseworker	☐ Hospital	☐ Health related support group	☐ Other_____
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You can either fax or mail a copy of this form back to the HIPP program.

Fax: (855) 357-1130

Address: AL HIPP, 8553571130, PO BOX 240756, AL 36124

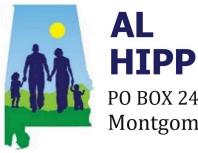
If you have any questions about this application, contact our office at our toll free number 8556925447.

For faster processing, attach a copy of the front and back of your **insurance card, employer rate sheet** (if available), **summary of benefits**, and a recent **paystub or other verification** to show your premium payment.

Toll free phone: 8556925447 | Monday to Friday, 8am to 5pm
Fax: (855) 357-1130 | Website: www.MyALHIPP.com

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FORM TWO: Alabama Health Insurance Premium Payment Application

Private policyholders: Complete FORM ONE and return it to the AL HIPP program. You may discard FORM TWO.

Employer-sponsored policyholders: Complete FORM ONE and FORM TWO and return it to the Alabama HIPP program. FORM TWO should be completed by the policyholder's EMPLOYER, such as a Human Resource representative or Benefits Coordinator.

1. Has employment terminated for the employee listed above? ☐ YES, Date: _____ ☐ NO

2. Employer Information:

Employer Name: _____ Federal Tax ID (Mandatory): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

How many full time individuals does your company currently employ? _____

3. Employer-sponsored health insurance information:

Do you offer insurance to your employees? ☐ YES ☐ NO

If YES, please complete the rate table below.

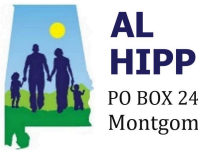
*Please complete the table below using family plan rates for each health insurance plan offered OR attach your company rate sheet. Also, please provide a **Summary of Benefits** for the health insurance plan accessible to the applicant.*

	Carrier Name	Plan	Persons Covered	Monthly Employer Contribution	Monthly Employee Contribution	Group #
Individual						
Individual + Spouse						
Individual + Child						
Family						

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FORM TWO (continued): Alabama Health Insurance Premium Payment Application

3. Employer-sponsored health insurance information (continued):

If you answered Yes to "Do you offer insurance to your employees?," does this individual have access to purchasing a family plan? ☐ YES ☐ NO

When does your company's open enrollment period start and end (If applicable)? _____

4. Employee's History:

Has the individual listed above withdrawn from a family health plan within the last six months? ☐ YES ☐ NO

If YES, which plan? _____ Plan Termination Date: _____

5. Your Information:

Name (Print): _____ Signature: _____

Your Title: _____ Date Signed: _____

Phone: _____ Ext: _____

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Fax: (855) 357-1130

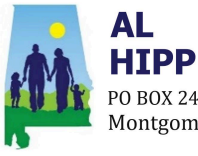
Mailing address: AL HIPP
PO BOX 240756
MONTGOMERY, AL 36124

If you have any questions about this application form, contact our office at our toll free number
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Alabama HIPP (ALHIPP) Member Renewal Checklist

To ensure that we have the most recent information about you and confirm that you continue to remain eligible for the Alabama HIPP program, please return the following Renewal Forms and documentation listed below within 10 days of the date of this renewal packet. Please follow the instructions in the letter and forward items for consideration.

Have you included?

- _____ FORM 1 – The policyholder should complete FORM ONE-of the renewal application
- _____ FORM 2 – The policyholder’s employer should complete FORM TWO of the renewal application
- _____ Front and back of policyholder’s insurance card
- _____ Employer rate sheet
- _____ Summary of benefits
- _____ A recent paystub or other verification to show your premium payment

You can either fax or mail a copy of all items listed back to the HIPP program.

Fax:

Address: AL HIPP, PO BOX 240756, MONTGOMERY, AL 36124

If you have questions about the renewal packet, contact our office at our toll free number 8556925447.

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