APPLICATION FOR HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

Participants should complete this application and submit it with a copy of their policy information by email to MHD.HIPP@dss.mo.gov or by mail to: MO HealthNet Division, ATTN: HIPP Program, P.O. Box 6500, Jefferson City, MO 65102-6500. It may also be given to a Family Support Division (FSD) Eligibility Specialist to be forwarded to the HIPP Program. HIPP may be contacted at (573) 751-2005.

Section 1. Policyholder Information

Policyholder Name	Policyholder Social Security Number	Phone Number	
Street Address	City	State	Zip

Section 2. Insurance Information

Insurance Name	Insurance Phone Number		
Claim Mailing Address	City	State	Zip
Policy Number	Policy Group Number		

Section 3. List All Persons That Can Be Covered Under the Policy Including Policyholder

Name	Birthdate	MO HealthNet Eligible	MO HealthNet ID #	Social Security #
		☐ Yes ☐ No ☐ App		
		☐ Yes ☐ No ☐ App		
		☐ Yes ☐ No ☐ App		
		☐ Yes ☐ No ☐ App		

Section 4

1. Are you currently enrolled in this policy? ☐ Yes ☐ No	2. Are your dependents currently enrolled in this policy? ☐ Yes ☐ No		
3. Are you currently: ☐ Employed ☐ Unemployed ☐ On family or medical leave	4. Is this policy: ☐ Through an employer ☐ Through a former employer ☐ Privately purchased		
5. What is the amount of the premium for Medical coverage? $	6. Are your premiums: ☐ Payroll deducted ☐ Paid directly to the insurance company ☐ Paid directly to the employer		
7. Premiums are paid: ☐ Monthly ☐ Biweekly ☐ Semimonthly ☐ Weekly ☐ Quarterly	8. Next premium due date:		
9. Employer or Former Employer Name	Employer or Former Employer Phone Number		
Employer or Former Employer Street Address	City	State	Zip

IMPORTANT

YOU MUST PROVIDE COPIES OF FRONT AND BACK OF INSURANCE IDENTIFICATION CARDS, OPEN 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.

10. Signature of Policyholder		Date
Signature of Care Coordinator		Date
Care Coordinator Agency/Affiliation	Title	Phone Number

If you are a Veteran in the state of Missouri and are interested in learning more about benefits and resources available to you and your dependents, visit https://mvc.dps.mo.gov/MoVeteransInformation/Survey/DSS.

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 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 other sources (employer based policies, 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 and cost-sharing for MO HealthNet participants on the policy.

MO HealthNet participants are not eligible for the HIPP program if they are covered by a Managed Care Plan, are eligible for or enrolled in Medicare, or if the policy is court ordered.

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.
Section 3	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.
Section 4	1. Indicate whether you are currently covered by this insurance policy. 2. Indicate whether your spouse or children are currently covered by this policy. 3. Indicate your current employment status. 4. 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. 5. Indicate the amount of your share of the premium for medical coverage. 6. Indicate if your premiums are currently paid through payroll deduction, direct payment to the insurance company, or direct payment to the employer. 7. 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). 8. List the date your next premium is due. 9. List your employer or former employer's name, address and telephone number. Employers are contacted to verify payroll deductions, rates, etc. 10. Sign and date the application form at the bottom.