

Health Insurance Premium Payment Program Application

Please answer all of the questions and sign the application. If you have any questions or need help filling out this form, please call **515-974-3282** or **1-888-346-9562** (toll-free). We will be happy to help you!

Answer these questions about the person who has health insurance.

Policyholder	Home Phone () Work Phone ()
Street Address	City State Zip Code
Mailing Address (if different)	City State Zip Code

Information about the health insurance company

Name of Insurance Company	Policy Number
Street Address	City State Zip Code

List all the people living in your home – Start with yourself

Name (Last, First)	Birth Date Month/ Date/Year	Relationship to you?	Social Security Number	Does this person get Medicaid? Y/N	State ID number for Medicaid?	Does this person get Medicare? Y/N	Is this person currently covered by your insurance? Y/N
		Self					

Is this: an **Individual Policy** **COBRA** or an **Employer Plan**? (Check one)

For **Employer Policies** or **COBRA**, list the name, city and state of employer: _____

How often do you pay the insurance premium? _____ How much? \$ _____

How do you pay your premiums? (Check one)

Payroll deduction Check Automatic withdrawal Other: _____

What are the yearly deductibles for the health insurance: Single \$ _____ Family \$ _____

If all Medicaid eligible people in your home are not currently enrolled in your employer policy or COBRA, can you or family members still enroll? If so, what is the earliest date? _____

Signature or Mark of Applicant	Date
--------------------------------	------