**HCA Premium Payment Program Intake**

 (WAC Chapter 182-558) **HOH #:       \_\_\_WA**

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| Your name  | Telephone number ()  | Email address (optional)  |
| Mailing address | City | State | ZIP code |
| **Please list below all family members who are on your Health Insurance policy.** |
| Name*(please enter subscriber’s information on line 1)*  | Relationship to subscriber | Date of birth | Enrolled in Apple Health (Medicaid)? | Social Security number or ProviderOne number |
| 1.  | **SELF** |  | [ ]  Yes [ ]  No |  |
| 2.  |  |  | [ ]  Yes [ ]  No |  |
| 3.  |  |  | [ ]  Yes [ ]  No |  |
| 4.  |  |  | [ ]  Yes [ ]  No |  |
| 5.  |  |  | [ ]  Yes [ ]  No |  |
| 6.  |  |  | [ ]  Yes [ ]  No |  |
| 7.  |  |  | [ ]  Yes [ ]  No |  |
| 8.  |  |  | [ ]  Yes [ ]  No |  |
| **Please provide your Health Insurance Provider information.**  |
| Name of your private health insurance company   | Policy number  | Telephone number()  |
| Company address | City | State | ZIP code |
| Source of insurance: [ ]  Employer\* [ ]  COBRA [ ]  Individual [ ]  Other: When is your open enrollment date? // Effective date: // |
| **\*If employer, please attach a copy of a recent paycheck stub, and fill in the following:** |
| Employers name | Telephone number ()  |
| **Health Insurance Premium** (from your billing statement or employer/paycheck) |
| How much do you pay for this insurance? $  Is it pre-tax? [ ]  Yes [ ]  NoHow often do you pay? [ ]  Weekly [ ]  Monthly [ ]  Bi-weekly [ ]  Semi-monthly | What is the annual deductible amount for: Individuals: $  Family: $   |
| Name of your dental insurance company | Address of dental insurer | Telephone number()  |
| ***By signing below, I attest that the information provided above is true, correct and complete, the best of my knowledge.*** |
| Signature | Date |

**For fastest service:**

* Provide all information requested.
* Attach current copies of your health insurance payment or a recent paystub if your employer provides health insurance.
* Attach current copies of your insurance card (front and back).
* Attach W-9

**Return to:**

 Washington State Health Care Authority, Premium Payment Program, PO Box 45518, Olympia, WA 98599-5518

 Fax: 1-877-893-3810; Phone: 1-800-562-3022, Ext. 15473
 Monday­-Friday, 10 a.m. to 1 p.m.