**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  No  How 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.