The Louisiana Health Insurance Premium Payment Program

LaHIPP

THE LOUISIANA HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

Employer Health Insurance Information Form

- This form is to be completed by the employer providing health insurance to the LaHIPP applicant, in order to make a final determination of eligibility for premium reimbursement of health insurance. Although some information may not relate to the applicant and/or they may not currently have health insurance, this information is still needed.
- If you need extra space, use a separate sheet of paper.
- If you have any questions, call **1-855-618-5488** Monday–Friday between 8:00 AM–4:30 PM to speak with a LaHIPP representative, or visit us online at our website ldh.la.gov/lahipp.
- Complete and mail this form to **LaHIPP, 7389 Florida Blvd. Suite 400, Baton Rouge, LA 70806** or fax it to **1-855-618-5486**. You can also e-mail a copy of this form to La.HIPP@la.gov.

What is your preferred language? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: ____________

► *Please **PRINT** clearly in black ink.*

1 — Employer Information

Employer name	
Employer address	
Employer phone number ( )	Does this employer offer health insurance to its employees? ☐ Yes ☐ No *(If **NO**, skip to section 6)*

2 — Employer Insurance Information

Insurance carrier name	
Insurance carrier phone number ( )	Are multiple plans offered by this insurance carrier? ☐ Yes ☐ No *(Please submit a summary of benefits for all plans with this form)*
Is there an Open/Annual Enrollment Period? ☐ Yes ☐ No	If **NO**, when would changes to insurance go into effect?
If **YES**, what are the dates for this period? Begin date: End date:	When would changes to insurance go into effect for this period?

3 — Insurance Coverage Information

What coverage is provided by your insurance carrier? *(Check all that apply)*

☐ Major Medical ☐ Dental ☐ Inpatient Hospital ☐ Outpatient Hospital
☐ Cancer Only ☐ Pharmacy ☐ PPO ☐ HMO
☐ Skilled Nursing ☐ Medicare Supplement ☐ Emergency Transportation ☐ Home Health
☐ Vision ☐ High Deductible — Amount: ____________________ ☐ Other: ______________

Tell us your employee's share of monthly premiums. If any standard tiers are not applicable, please indicate with N/A)

Standard Tiers	Monthly premium share	Other Tiers *(if applicable)*	Monthly premium share
Employee Only	$		$
Employee and Children	$		$
Employee and Spouse	$		$
Family	$		$

How frequent are premium deductions?

☐ Weekly (**48** times a year) ☐ Weekly (**52** times a year) ☐ Biweekly (**24** times a year) ☐ Biweekly (**26** times a year)
☐ Monthly ☐ Semi-Monthly ☐ Annually ☐ Other: ____

4 — Employee Information (ACTIVE)

Is the LaHIPP applicant a **current** employee or someone who receives coverage from a **current** employee's insurance plan?
☐ Yes ☐ No *(if **NO**, skip to section 5)*

Provide the following information for the active employee.

First name Middle initial Last name Suffix *(Sr., Jr., etc.)*

Social Security number Date of birth Sex ☐ Male ☐ Female

Insurance policy number Insurance group number

Is the first month's premium deducted from this employee's paycheck before coverage becomes effective? ☐ Yes ☐ No

Can changes be made to this coverage by the employee at times other than open/annual enrollment? ☐ Yes ☐ No

Provide the following information for all dependants of the active employee who are enrolled or have been enrolled in their health insurance plan. Include information for the active employee.

Name	Social Security Number	Date of Birth	Insurance Effective Date	Insurance End Date

5 — Employee Information (TERMINATED)

Is the LaHIPP applicant a **terminated** employee or someone who receives coverage from a **terminated** employee's insurance plan? ☐ Yes ☐ No *(if* ***NO****, skip to section 6)*

Provide the following information for the terminated employee.

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

When did employment end?	Did this employee elect to enroll in COBRA coverage? ☐ Yes ☐ No

If **YES**, what was the name of their COBRA contact?

COBRA phone number ( )	COBRA fax number *(if applicable)* ( )

Provide the following information for all dependants of the terminated employee who are enrolled or have been enrolled in their health insurance plan. Include information for the terminated employee.

Name	Social Security Number	Date of Birth	Insurance Effective Date	Insurance End Date

6 — Form Filer Information and Signature

Name of employer representative completing form

Employer mailing address

Employer phone number ( )	Employer fax number *(if applicable)* ( )

Sign here:	Date:

Thank you for your time in providing Medicaid and LaHIPP the opportunity to assist your employee!