Kentucky Integrated Health Insurance Premium Payment Program Application

KI HIPP
Kentucky Integrated Health Insurance Premium Payment

KIHIPP-100

Medicaid can help eligible individuals and families pay for other health coverage offered by your job, COBRA, United Mine Worker insurance or Retiree Health Plan. The Medicaid program that can help pay your premium costs is called 'Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Program'. Complete this form if you ('Primary Policy holder') have an offer of health insurance coverage. Use the KI-HIPP Application Form instructions at benefind.ky.gov to help complete this form.

Step 1: Tell us about you: Primary Policy Holder Information

1. First Name	Middle Name	Last Name
2. Social Security Number	3. Date of Birth (MM/DD/YYYY) _____/____/_____	4. Medicaid ID (if known)
5. Home Address		
6. City	7. State	8. Zip Code
9. Email	10. Phone Number	

Step 2: Tell us about the health insurance or COBRA benefits the person in Step 1 can get

11. Health Insurance Company Name	12. Plan name
13. Policy ID	14. Group ID (If known)
15. What is the Coverage start date? (MM/DD/YYYY) _____/_____/_____	16. What is the Coverage End date? (MM/DD/YYYY) _____/_____/_____ (if known)
17. Is this COBRA Insurance? ☐ Yes ☐ No	18. Do you use tobacco? (this question does not impact your Medicaid coverage)? ☐ Yes ☐ No

Step 3: Tell us about the employer or other place that offers the health insurance or COBRA

19. Name	20. Employer Identification Number (EIN) (if known)	
21. Other Name (if applicable)		
22. Address		
23. City	24. State	25. Zip Code
26. Employer/Business Type Contact Name	27. Employer/Business Type Contact Phone Number	
28. Employer/Business Type Contact Email		

Step 4: Additionally, Tell us about your Dental or Vision insurance details, only if you are enrolled

29. Dental Insurance Company Name	30. Plan name
31. Policy ID	32. Group Number (If known)

33. What is the Coverage start date? (MM/DD/YYYY) _____/_____/_____	34. What is the Coverage End date? (MM/DD/YYYY) _____/_____/_____ (if known)
35. Vision Insurance Company Name	36. Plan name
37. Policy ID	38. Group Number (If known)
39. What is the Coverage start date? (MM/DD/YYYY) _____/_____/_____	40. What is the Coverage End date? (MM/DD/YYYY) _____/_____/_____ (if known)

Step 5: Who else has coverage on your insurance?

Spouse	
a. Name (First, Middle, Last)	b. Social Security Number (SSN)
c. Date of Birth (MM/DD/YYYY) _____/____/_____	d. Medicaid ID (if known)
e. Coverage start date (if known) _____/____/_____	f. Coverage end date (if known) _____/____/_____
g. Do you use tobacco? (this question does not impact your Medicaid coverage)? ☐ Yes ☐ No	

Dependent 1	
a. Name (First, Middle, Last)	b. Social Security Number (SSN)
c. Date of Birth (MM/DD/YYYY) _____/____/_____	d. Medicaid ID (if known)
e. Relationship with the Employee Son ☐ Daughter ☐ Other	
f. Coverage start date (if known) _____/____/_____	g. Coverage end date (if known) _____/____/_____
h. Do you use tobacco? (this question does not impact your Medicaid coverage)? ☐ Yes ☐ No	

Dependent 2	
a. Name (First, Middle, Last)	b. Social Security Number (SSN)
c. Date of Birth (MM/DD/YYYY) _____/____/_____	d. Medicaid ID (if known)
e. Relationship with the Employee Son ☐ Daughter ☐ Other	
f. Coverage start date (if known) _____/____/_____	g. Coverage end date (if known) _____/____/_____
h. Do you use tobacco? (this question does not impact your Medicaid coverage)? ☐ Yes ☐ No	

Dependent 3	
a. Name (First, Middle, Last)	b. Social Security Number (SSN)
c. Date of Birth (MM/DD/YYYY) _____/____/_____	d. Medicaid ID (if known)
e. Relationship with the Employee Son ☐ Daughter ☐ Other	

f. Coverage start date (if known) _____/____/_____	g. Coverage end date (if known) _____/____/_____
h. Do you use tobacco? (this question does not impact your Medicaid coverage)? ☐ Yes ☐ No	

Dependent 4	
a. Name (First, Middle, Last)	b. Social Security Number (SSN)
c. Date of Birth (MM/DD/YYYY) _____/____/_____	d. Medicaid ID (if known)
e. Relationship with the Employee Son ☐ Daughter ☐ Other	
f. Coverage start date (if known) _____/____/_____	g. Coverage end date (if known) _____/____/_____
h. Do you use tobacco? (this question does not impact your Medicaid coverage)? ☐ Yes ☐ No	

If you have more than 4 dependents, use Appendix A to provide more information about your household.

Authorization

26. Member Signature and Date

- I am signing this form under penalty of perjury, which means I have given true answers to all the questions on this form including appendix to the best of my knowledge and belief. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
    - I know that I must tell the Department of Medicaid Services (DMS) if anything changes from what I wrote on this form within 30 days of the change. I can visit benefind.ky.gov or call 855-459-6328 to report any changes.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I understand that my eligibility for Medicaid will not be impacted by my tobacco use status. If my plan is not eligible for KI-HIPP, I may get Medicaid.
- I understand that DMS will check my answers using information in databases from the Internal Revenue Service (IRS), Social Security Administration, the Department of Homeland Security, and/or any other trusted sources. If the information does not match, I may be asked to send proof.

If I am eligible for Kentucky Integrated Health Insurance Premium Payment Program:

- I understand that if Kentucky Integrated Health Insurance Premium Payment pays for a medical expense, any other health insurance or legal settlement payments will go to Medicaid, as applicable, to reimburse it for the expense.
- I understand that my Health Coverage form may be reviewed to make sure that eligibility was determined correctly. If my form is reviewed, I must cooperate with the review.

Signature	Date (MM/DD/YYYY) _____/____/_____

If you need help with your form or to complete faster online, go to benefind.ky.gov or call 855-459-6328. You may upload the documents on benefind.ky.gov, or send it to:

KI-HIPP Address: CHFS KI-HIPP Unit
275 E. Main St., 6C-A
Frankfort, KY 40621
Fax: 502-564-3232
Email: KIHIPP.PROGRAM@KY.GOV

Step 6: Submit the required documents for each offer of health insurance:

- ☐ Summary of Benefits and Coverage (SBC).
- ☐ Certificate of Coverage, proof of plan exclusion or plan document.
- ☐ Proof of health insurance premium payment, if available.
- ☐ Premium rate sheet. This may be found in your enrollment materials.

Appendix A: Additional Dependents

If you have more than four dependents that have access to health coverage under your insurance, please complete this form as many times as needed to reflect all members in the household that can be covered.

Shortened Primary Policy Holder Information

1. First Name	Middle Name	Last Name
2. Date of Birth (MM/DD/YYYY)	3. Medicaid ID (if known)	

Shortened Employer/Business Type Information

Provide the following information so we can match these additional dependents to existing information with us provided above.

4. Employer Name/Business Type	
5. City	6. State

Who else has coverage on your insurance?

Dependent #_	
a. Name (First, Middle, Last)	b. Social Security Number (SSN)
c. Date of Birth (MM/DD/YYYY) _____/____/_____	d. Medicaid ID (if known)
e. Relationship with the Employee Son ☐ Daughter ☐ Other	
f. Coverage start date (if known) _____/____/_____	g. Coverage end date (if known) _____/____/_____
h. Do you use tobacco? (this question does not impact your Medicaid coverage)? ☐ Yes ☐ No	

Dependent #_	
i. Name (First, Middle, Last)	j. Social Security Number (SSN)
k. Date of Birth (MM/DD/YYYY) _____/____/_____	l. Medicaid ID (if known)
m. Relationship with the Employee Son ☐ Daughter ☐ Other	
n. Coverage start date (if known) _____/____/_____	o. Coverage end date (if known) _____/____/_____
p. Do you use tobacco? (this question does not impact your Medicaid coverage)? ☐ Yes ☐ No	

Dependent #_	
q. Name (First, Middle, Last)	r. Social Security Number (SSN)
s. Date of Birth (MM/DD/YYYY) _____/____/_____	t. Medicaid ID (if known)
u. Relationship with the Employee Son ☐ Daughter ☐ Other	
v. Coverage start date (if known) _____/____/_____	w. Coverage end date (if known) _____/____/_____
x. Do you use tobacco? (this question does not impact your Medicaid coverage)? ☐ Yes ☐ No	

Appendix B: Other Insurance Coverage

If you have more than one offering, please complete this form for each additional offering your health insurance.

Step 1: Shortened Primary Policy Holder Information

1. First Name	Middle Name	Last Name
2. Date of Birth (MM/DD/YYYY)	3. Medicaid ID (if known)	

Step 2: Tell us about the health insurance or COBRA benefits the person in Step 1 can get

4. Health Insurance Company Name	5. Plan name
6. Policy ID	7. Group Number (If known)
8. What is the Coverage start date? (MM/DD/YYYY) _____/_____/_____	9. What is the Coverage End date? (MM/DD/YYYY) _____/_____/_____ (if known)
10. Is this COBRA Insurance? ☐ Yes ☐ No	

Step 3: Tell us about the employer or other place that offers the health insurance or COBRA

11. Name/Business Type	12. Employer Identification Number (EIN) (if known)	
13. Other Name (if applicable)		
14. Address		
15. City	16. State	17. Zip Code
18. Employer/Business Type Contact Name	19. Employer/Business Type Contact Phone Number	
20. Employer/Business Type Contact Email		

Step 4: Additionally, Tell us about your Dental or Vision insurance details, only if you are enrolled

21. Dental Insurance Company Name	22. Plan name
23. Policy ID	24. Group Number (If known)
25. What is the Coverage start date? (MM/DD/YYYY) _____/_____/_____	26. What is the Coverage End date? (MM/DD/YYYY) _____/_____/_____ (if known)
27. Vision Insurance Company Name	28. Plan name
29. Policy ID	30. Group Number (If known)
31. What is the Coverage start date? (MM/DD/YYYY) _____/_____/_____	32. What is the Coverage End date? (MM/DD/YYYY) _____/_____/_____ (if known)

Step 5: Who else has coverage on your insurance?

Spouse	
h. Name (First, Middle, Last)	i. Social Security Number (SSN)
j. Date of Birth (MM/DD/YYYY) _____/____/_____	k. Medicaid ID (if known)
l. Coverage start date (if known) _____/____/_____	m. Coverage end date (if known) _____/____/_____
Dependent 1	
i. Name (First, Middle, Last)	j. Social Security Number (SSN)
k. Date of Birth (MM/DD/YYYY) _____/____/_____	y. Medicaid ID (if known)
l. Relationship with the Employee Son ☐ Daughter ☐ Other	
m. Coverage start date (if known) _____/____/_____	n. Coverage end date (if known) _____/____/_____
Dependent 2	
i. Name (First, Middle, Last)	j. Social Security Number (SSN)
k. Date of Birth (MM/DD/YYYY) _____/____/_____	l. Medicaid ID (if known)
m. Relationship with the Employee Son ☐ Daughter ☐ Other	
n. Coverage start date (if known) _____/____/_____	o. Coverage end date (if known) _____/____/_____
Dependent 3	
i. Name (First, Middle, Last)	j. Social Security Number (SSN)
k. Date of Birth (MM/DD/YYYY) _____/____/_____	p. Medicaid ID (if known)
l. Relationship with the Employee Son ☐ Daughter ☐ Other	
m. Coverage start date (if known) _____/____/_____	n. Coverage end date (if known) _____/____/_____
Dependent 4	
i. Name (First, Middle, Last)	j. Social Security Number (SSN)
k. Date of Birth (MM/DD/YYYY) _____/____/_____	q. Medicaid ID (if known)
l. Relationship with the Employee Son ☐ Daughter ☐ Other	
m. Coverage start date (if known) _____/____/_____	n. Coverage end date (if known) _____/____/_____

If you have more than 4 dependents, use Appendix A to provide more information about your household.