

Medicaid can help eligible individuals and families pay for health insurance coverage offered by your job, COBRA, United Mine Workers, or a Retiree Health Plan. This Medicaid program is called Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Program. Complete this form if you (the Primary Policy Holder) have access to or enrollment in health insurance coverage. Use the KI-HIPP Application Form instructions at benefind.ky.gov if you need help completing this form.

Step 1: Primary Policy Holder Information (This is the person who carries the insurance.)

1. First Name		Middle Name		Last Name	
2. Social Security Number		3. Date of Birth (MM/DD/YYYY) ____/____/____		4. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
5. Use Tobacco?*					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
6. Home Address					
7. City		8. State		9. Zip Code	
10. Mailing Address, if different					
11. City		12. State		13. Zip Code	
14. Phone Number		15. Phone Type <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other		16. Email	
17. How would you like to receive notices? <input type="checkbox"/> Paper <input type="checkbox"/> Electronic – email only <input type="checkbox"/> Electronic – email & SMS				18. Coverage Start Date ____/____/____	

*Tobacco use question is for informational purposes only and does not affect Medicaid coverage.

Step 2: Health Insurance Policy Information

19. Do you have access to this insurance plan or are you already enrolled? <input type="checkbox"/> Access <input type="checkbox"/> Enrolled					
20. What is the source of this health insurance plan? <input type="checkbox"/> Employer-Sponsored Insurance <input type="checkbox"/> COBRA <input type="checkbox"/> United Mine Workers <input type="checkbox"/> Retiree Health Plan					
21. Employer Name			22. Employer Phone Number		
23. Health Insurance Company Name			24. Health Insurance Company Phone Number		
25. Health Insurance Company Address					
26. City		27. State		28. Zip Code	
29. Plan Name			30. Plan Start Date (MM/DD/YYYY) ____/____/____		
31. Group Number, if enrolled			32. Policy ID Number, if enrolled		
33. Tier of Coverage <input type="checkbox"/> Employee <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + Dependents <input type="checkbox"/> Family		34. Premium per Frequency \$ _____		35. Frequency <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly	

Step 3: Covered Individuals

Tell us about the individuals that are covered on your health insurance plan if you are enrolled, or the individuals that you hope to cover if you have access only.

Spouse				
a. First Name		Middle Name		Last Name
b. Social Security Number	c. Date of Birth (MM/DD/YYYY) ____/____/____		d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	e. Use Tobacco?*" Yes <input type="checkbox"/> No <input type="checkbox"/>
f. Coverage Start Date ____/____/____	g. Is this person on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		h. Medicaid ID Number, if known	
Dependent 1				
a. First Name		Middle Name		Last Name
b. Social Security Number	c. Date of Birth (MM/DD/YYYY) ____/____/____		d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	e. Use Tobacco?*" Yes <input type="checkbox"/> No <input type="checkbox"/>
f. Coverage Start Date ____/____/____	g. Is this person on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		h. Medicaid ID Number, if known	
i. Relationship to Policy Holder <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____				
Dependent 2				
a. First Name		Middle Name		Last Name
b. Social Security Number	c. Date of Birth (MM/DD/YYYY) ____/____/____		d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	e. Use Tobacco?*" Yes <input type="checkbox"/> No <input type="checkbox"/>
f. Coverage Start Date ____/____/____	g. Is this person on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		h. Medicaid ID Number, if known	
i. Relationship to Policy Holder <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____				
Dependent 3				
a. First Name		Middle Name		Last Name
b. Social Security Number	c. Date of Birth (MM/DD/YYYY) ____/____/____		d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	e. Use Tobacco?*" Yes <input type="checkbox"/> No <input type="checkbox"/>
f. Coverage Start Date ____/____/____	g. Is this person on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		h. Medicaid ID Number, if known	
i. Relationship to Policy Holder <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____				
Dependent 4				
a. First Name		Middle Name		Last Name
b. Social Security Number	c. Date of Birth (MM/DD/YYYY) ____/____/____		d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	e. Use Tobacco?*" Yes <input type="checkbox"/> No <input type="checkbox"/>
f. Coverage Start Date ____/____/____	g. Is this person on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		h. Medicaid ID Number, if known	
i. Relationship to Policy Holder <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____				

*Tobacco use question is for informational purposes only and does not affect Medicaid coverage.

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

Step 4: Authorization

- 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 for 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 Program 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) ____/____/____
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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 required in step 5 on benefind.ky.gov, or send to:

KI-HIPP Address: CHFS KI-HIPP Unit
275 E. Main St., 6C-A
Frankfort, KY 40621

KI-HIPP Email: kihipp.program@ky.gov

Step 5: Verification

You must submit the required documents:

- Summary of Benefits and Coverage (SBC), including all deductibles, coinsurance amounts, copays, and covered services;
- Premium rate sheet;
- Health insurance card, front and back, if enrolled; and
- Recent paystub, showing insurance deduction, if enrolled.

Appendix A: Additional Covered Individuals

Tell us about the individuals that are covered on your health insurance plan if you are enrolled, or the individuals that you hope to cover if you have access only. Only complete Appendix A if you ran out of room in Step 3. You can use as many Appendix A pages as you need to list your dependents.

Dependent _____				
a. First Name		Middle Name		Last Name
b. Social Security Number	c. Date of Birth (MM/DD/YYYY) ____/____/____		d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	e. Use Tobacco?* <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Coverage Start Date ____/____/____	g. Is this person on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		h. Medicaid ID Number, if known	
i. Relationship to Policy Holder <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____				
Dependent _____				
a. First Name		Middle Name		Last Name
b. Social Security Number	c. Date of Birth (MM/DD/YYYY) ____/____/____		d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	e. Use Tobacco?* <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Coverage Start Date ____/____/____	g. Is this person on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		h. Medicaid ID Number, if known	
i. Relationship to Policy Holder <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____				
Dependent _____				
a. First Name		Middle Name		Last Name
b. Social Security Number	c. Date of Birth (MM/DD/YYYY) ____/____/____		d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	e. Use Tobacco?* <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Coverage Start Date ____/____/____	g. Is this person on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		h. Medicaid ID Number, if known	
i. Relationship to Policy Holder <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____				
Dependent _____				
a. First Name		Middle Name		Last Name
b. Social Security Number	c. Date of Birth (MM/DD/YYYY) ____/____/____		d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	e. Use Tobacco?* <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Coverage Start Date ____/____/____	g. Is this person on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		h. Medicaid ID Number, if known	
i. Relationship to Policy Holder <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____				
Dependent _____				
a. First Name		Middle Name		Last Name
b. Social Security Number	c. Date of Birth (MM/DD/YYYY) ____/____/____		d. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	e. Use Tobacco?* <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Coverage Start Date ____/____/____	g. Is this person on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		h. Medicaid ID Number, if known	
i. Relationship to Policy Holder <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other _____				