

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
MICHIGAN DRUG ASSISTANCE PROGRAM (MIDAP)
PREMIUM ASSISTANCE – SIX MONTH VERIFICATION

Client Name: _____

MIDAP Member ID: _____ Date of Birth: ____ / ____ / ____

Current Gross Monthly Income: _____

What type of insurance plan do you currently have?

- Qualified Health Plan (Marketplace)
- Medicare Prescription Plan (Med D/Advantage Plan)
- COBRA (IAP Plus)

Has anything changed with your insurance in the past 6 months?

- NO
- YES

If you answered yes, please indicate what has changed:

- I am now using the Healthy Michigan Plan as my primary insurance.
- I now have employer sponsored insurance, effective ____ / ____ / ____.
*Please note that MIDAP does not assist with premium payments for employer sponsored insurance plans.
- I have a new COBRA administrator. Payments should be sent to the new address of:

- Other, please describe below:

Please fill out this form and return by mail or fax to:

MIDAP
109 W. Michigan Ave, 9th Floor
Lansing, MI 48913
FAX: (517) 335-7723



Premium rate changes, past due amounts, account credits and account closures can be made on the Premium Assistance adjustment form found on our website at www.michigan.gov/DAP.

Completion Authority: PA 368 of 1978 is voluntary, but is necessary to receive coverage under the Michigan Drug Assistance Program. Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.