

MIDAP - 2013/2014
Health Insurance Premium
Payment Assistance Application/Update Form



I. Eligibility Criteria

MIDAP Member ID # (8 digit numer found on SGRX/MIDAP Card)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1. Are you eligible for Medicare? (Part A, B, C, D)	<input type="radio"/> Yes		<input type="radio"/> No				
2. Are you eligible for employer sponsored health insurance?	<input type="radio"/> Yes		<input type="radio"/> No				
3. Are you a resident of the state of Michigan?	<input type="radio"/> Yes		<input type="radio"/> No				
4. What is your total monthly income from all sources before taxes? (see instructions)	<input type="text"/>						<input type="text"/>
5. What is your household size? (see instructions)	<input type="text"/>						<input type="text"/>

II. Applicant Information

Applicants Name (First, MI, Last)		Social Security Number		<input type="text"/>
Address (Please note all MIDAP related mail will be sent to this address)		City	State	Zip Code
Phone Number	Date of Birth (MM/DD/YYYY)	Email Address		
Gender	<input type="radio"/> Male	<input type="radio"/> Female	Transgender:	<input type="radio"/> Male to Female <input type="radio"/> Female to Male

III. Premium Request Type (Choose only one)

<input type="radio"/> Medicare Part D	Start Date (MM/DD/YYYY)	You must apply for Extra Help/Low Income Subsidy through Social Security (SSA.gov) and attach proof of application and/or letter of decision		
<input type="radio"/> COBRA	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)	Attached all COBRA notification paperwork. Send COBRA election form to COBRA Administration	
<input type="radio"/> Qualified Health Plan(QHP)	Start Date (MM/DD/YYYY)	Attach a copy of Marketplace generated assessment letter for tax credits and cost sharing reductions eligibility and your QHP billing statement/invoice		

IV. Insurance Plan Information (Your most current billing statement must be included with this application)

Payee Name		Payee Phone Number		
Payee Address (Number, Street, or P.O.Box)		City	State	Zip Code
Carrier Name (If different than Payee Name)		Account Number	Member ID/Policy Number	
Monthly Premium Amount \$	Initial Payment Amount \$	Premium Due Date (MM/DD/YY)	Months covered by initial payment amount MM/YY	-to-

CONSENT: Please note that the information on this form is being used to determine eligibility for insurance premium and/or medication coinsurance provided by the Michigan Drug Assistance Program (MIDAP) under the Ryan White Treatment Extension Act of 2009. The information may be used to contact insurance companies, Consolidated Omnibus Budget Reconciliation Act (COBRA) administrators, employers and employer administered health insurance plans, insurance marketplace navigators, as well as any other governmental or public agencies as necessary to determine the extent of available health insurance and eligibility for insurance assistance. Failure to provide the information requested on this form will result in a delay in processing.

I authorize insurance companies, COBRA administrators, employer and employer administered health insurance plans, insurance marketplace navigators, as well as any other governmental or public agencies to release information to MIDAP with regard to insurance premiums, benefits, and other health services provided to me. I authorize payments of refunds to MIDAP for premiums paid by MIDAP on my behalf. I agree to return all refunds of premiums sent to me to MIDAP at: Revenue Operations, ATTN: COBRA, PO Box 30437, Lansing, Michigan 48909.

I agree to re-enroll annually for MIDAP services and to re-certify as required. I certify that the answers that I have given on this application and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of assistance provided by MIDAP. I understand that if my eligibility for MIDAP assistance changes that I will immediately notify MIDAP. I understand that I will notify MIDAP of changes to my policy including: increases to my monthly premium; change in billing address, or enrollment in an employer-based health insurance plan, Medicaid, or Medicare.

MIDAP Office Use Only:	
<input type="checkbox"/> Approved	
<input type="checkbox"/> Denied	
Initials _____	Date _____

Signature of Applicant: _____ Date _____