The Arkansas Health Insurance
Premium Payment Program

1818 N. Taylor Street #360
Little Rock, AR 72207

Date :

Dear Applicant,

The Arkansas Health Insurance (ARHIPP) is a program that helps working families and adults pay for health insurance coverage. To apply for the (ARHIPP) program, fill out the attached application and either fax or mail it back to us within 10 days. For faster processing, we ask that you please follow all instructions while completing your application.

Fax: 855-777-1001
Address: 1818 N. Taylor Street #360
Little Rock, AR 72207

If you have any questions, please contact the Arkansas Health Insurance program at our toll-free phone number 855-692-7447.

Sincerely,

The ARHIPP Team

The Arkansas Health Insurance
Premium Payment Program

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Date :

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Form One : Arkansas Health Insurance (ARHIPP) Application

FORM #1 is to be filled out by the APPLICANT. FORM #2 should be filled out by the policyholder's EMPLOYER, such as a Human Resource representative or Benefits Coordinator at your job.

1. Do you or anyone in your family receive Medicaid Benefits? ☐ YES ☐ NO

2. Do you or anyone in your family have health insurance? ☐ YES ☐ NO

2a. If you have insurance, is it through: ☐ EMPLOYER ☐ COBRA

2ai. what is the premium for Health insurance policy (if known)? $_____ These premiums are paid/ deducted:

☐ Weekly	☐ Biweekly	☐ Semimonthly	☐ Monthly	☐ Quarterly	☐ Other

2aii. Type of Coverage: ☐ Individual ☐ Individual and child ☐ Individual and Spouse ☐ Family

2b. If NO, can you or anyone in your family get other insurance through employment? ☐ YES ☐ NO
(If yes, tell us as much as you can about the healthcare plan you have access to as well as information about the employer providing the plan in questions 3 to 4. **If you answered no, and do not have any way of obtaining employer-sponsored insurance, please skip to form #2.**)

3. Please complete this section with the policyholder's information. If you do not have access to health insurance, please skip to form #2.

Name of Policy Holder: _____

Address: _____

City/ State/ Zip: _____

Home Phone: _____ Cell Phone: _____ Email (Required):_____

☐ Yes, it is okay to send important information about ARHIPP and my ARHIPP payments to my email address provided above. (Check box if this statement is accurate.)

SSN:_____ DOB: _____

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Insurance Company: _____

Policy Number (Mandatory): _____ Group Number: _____

Effective Date of Policy: _____ End Date: _____ Other: _____

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Form One (continued) : Arkansas Health Insurance (ARHIPP) Application

4. List all persons covered by the policy who are eligible for Medicaid. (Use extra paper if you need to?)

Name	Social Security Number	Birth Date	Medicaid ID Number	Relationship to Policyholder	Gender	Condition
		/ /				
		/ /				
		/ /				
		/ /				

5. DIRECT DEPOSIT (Check box to sign up for Direct Deposit)**:** ☐ If accepted onto the HIPP program, I would like to participate in Direct Deposit. By doing so, HIPP will deposit my payments into my checking or savings account and I will not receive a paper check. If I am not accepted into the program, HIPP will properly discard my banking information.

Bank Name: _____ Routing #: _____ Account #: _____

Type of Account (Please check one): ☐ Checking ☐ Savings

Checking account: Please do not forget to attach a copy of your voided check. Your voided check has your bank's routing number and bank account number; both are needed to send your payment by direct deposit.

Savings account: Your bank account number and ABA routing numbers are needed. You may contact your bank if you do not know these numbers.

If you have any questions about this application, contact our office at our toll free number 1-855-692-7447.

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For faster processing, attach a copy of the front and back of your **insurance card,** if you have one**, employer rate sheet, summary of benefits**, and a recent **paystub or other verification** to show your premium payment. If you have any questions, call our toll free number 1-855-692-7447.

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Form Two : Arkansas Health Insurance (ARHIPP) Application

FORM #2 should be filled out by the policyholder's EMPLOYER, such as a Human Resource representative or Benefits Coordinator. This form is to be completed on behalf of the Arkansas Health Insurance (ARHIPP) applicant that has selected "Employer" as their type of healthcare policy plan.

1. Has employment terminated for the employee listed above? ☐ YES, Date: _____ ☐ NO

2. Employer Information:

Employer Name: _____ Federal Tax ID **(Mandatory):** _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

How many full time individuals does your company currently employee? _____

3. Employer-sponsored health insurance information:

Do you offer insurance to your employees? ☐ YES ☐ NO

If YES, please complete the rate table below.

*Please complete the table below using family plan rates for each health insurance plan offered OR attach your company rate sheet. Also, please provide a **Summary of Benefits** for the health insurance plan accessible to the applicant.*

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ARHIPP

	Carrier Name	Plan	Persons Covered	Monthly Employer Contribution	Monthly Employee Contribution	Group #
Individual						
Individual + Spouse						
Individual + Child						
Family						

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Date

Form Two (continued) : Form One : Arkansas Health Insurance (ARHIPP) Application

3. Employer-sponsored health insurance information (continued):

If you answered No to "Do you offer insurance to your employees?", does this individual have access to purchasing a family plan? ☐ YES ☐ NO

When is your company's open enrollment period (If applicable)? _____

4. Applicant's History:

Has the individual listed above withdrawn from a family health plan within the last six months? ☐ YES ☐ NO

If YES, which plan? _____ Plan Termination Date: _____

5. Your Information:

Name (Print): _____ Signature: _____

Your Title:_____ Date Signed: _____

Phone: _____ Ext: _____

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You can either fax or mail a copy of this form back to the HIPP program.

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