

## HCA Premium Payment Program Intake

(WAC Chapter 182-558)

HOH #: \_\_\_\_\_ WA

| Your name  |                            | Telephone number<br>( )   | Email address (optional)                                 |  |
|--|----------------------------|---|--|--|
| Mailing address  |                            | City  | State  | ZIP code                                     |
| <b>Please list below all family members who are on your Health Insurance policy.</b>   |                            |   |  |  |
| Name<br><i>(please enter subscriber's information on line 1)</i>   | Relationship to subscriber | Date of birth   | Enrolled in Apple Health (Medicaid)?                     | Social Security number or ProviderOne number |
| 1.   | <b>SELF</b>                |   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 2.   |                            |   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 3.   |                            |   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 4.   |                            |   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 5.   |                            |   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 6.   |                            |   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 7.   |                            |   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 8.   |                            |   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| <b>Please provide your Health Insurance Provider information.</b>  |                            |   |  |  |
| Name of your private health insurance company  |                            | Policy number   | Telephone number<br>( )                                  |  |
| Company address  |                            | City  | State  | ZIP code                                     |
| Source of insurance: <input type="checkbox"/> Employer* <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other: _____ |                            |   |  |  |
| When is your open enrollment date? ____/____/____ Effective date: ____/____/____   |                            |   |  |  |
| <b>*If employer, please attach a copy of a recent paycheck stub, and fill in the following:</b>  |                            |   |  |  |
| Employers name   |                            |   | Telephone number<br>( )                                  |  |
| <b>Health Insurance Premium (from your billing statement or employer/paycheck)</b>   |                            |   |  |  |
| How much do you pay for this insurance? \$ _____   |                            | Is it pre-tax? <input type="checkbox"/> Yes <input type="checkbox"/> No | What is the annual deductible amount for:                |  |
| How often do you pay? <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly  |                            |   | Individuals: \$ _____ Family: \$ _____                   |  |
| Name of your dental insurance company  | Address of dental insurer  |   | Telephone number<br>( )                                  |  |
| <b>By signing below, I attest that the information provided above is true, correct and complete, the best of my knowledge.</b>                                   |                            |   |  |  |
| Signature  |                            |   | Date   |  |

**For fastest service:**

- Provide all information requested.
- Attach current copies of your health insurance payment or a recent paystub if your employer provides health insurance.
- Attach current copies of your insurance card (front and back).
- Attach W-9

**Return to:**

Washington State Health Care Authority, Premium Payment Program, PO Box 45518, Olympia, WA 98599-5518  
 Fax: 1-877-893-3810; Phone: 1-800-562-3022, Ext. 15473  
 Monday-Friday, 10 a.m. to 1 p.m.