



Health Insurance Form

UFI «UFI»

1. Household Information.

Head of Household Name:	First:	MI:	Last:	Suffix:
Address:	Street:			Apt:
	City:	State:	Zip:	Email:
Phone:	Primary:	Alternate:	Best time to call:	

2. Household Individuals. Please list all the people who live in your household.

Name	Are you applying for, or renewing health benefits for this person?	Is this person still living in the household?	Date of Birth (MM/DD/YYYY)	Social Security Number	Citizenship Status	Gender	Marital Status	Is this person a student?	How is this person related to the Head of Household?
	YES <input type="checkbox"/> No <input type="checkbox"/>	YES <input type="checkbox"/> No <input type="checkbox"/>						YES <input type="checkbox"/> No <input type="checkbox"/>	
	YES <input type="checkbox"/> No <input type="checkbox"/>	YES <input type="checkbox"/> No <input type="checkbox"/>						YES <input type="checkbox"/> No <input type="checkbox"/>	
	YES <input type="checkbox"/> No <input type="checkbox"/>	YES <input type="checkbox"/> No <input type="checkbox"/>						YES <input type="checkbox"/> No <input type="checkbox"/>	
	YES <input type="checkbox"/> No <input type="checkbox"/>	YES <input type="checkbox"/> No <input type="checkbox"/>						YES <input type="checkbox"/> No <input type="checkbox"/>	
	YES <input type="checkbox"/> No <input type="checkbox"/>	YES <input type="checkbox"/> No <input type="checkbox"/>						YES <input type="checkbox"/> No <input type="checkbox"/>	
	YES <input type="checkbox"/> No <input type="checkbox"/>	YES <input type="checkbox"/> No <input type="checkbox"/>						YES <input type="checkbox"/> No <input type="checkbox"/>	
	YES <input type="checkbox"/> No <input type="checkbox"/>	YES <input type="checkbox"/> No <input type="checkbox"/>						YES <input type="checkbox"/> No <input type="checkbox"/>	
	YES <input type="checkbox"/> No <input type="checkbox"/>	YES <input type="checkbox"/> No <input type="checkbox"/>						YES <input type="checkbox"/> No <input type="checkbox"/>	

3. Income Information. In the next two sections, please tell us about your household's earned and unearned income. You must send us proof of income.

Proof of earned and unearned income is:

- One pay stub from the last 60 days (send more stubs if your pay changes regularly) OR a note from your employer with your gross income & how often you get paid.
- If you are self-employed: last year's tax return with all schedules OR a list of your income and expenses signed and dated.
- Unemployment Financial Determination Letter.
- Social Security or Supplemental Security Income (SSI) award letter and/or 1099.
- Pension or Worker's Compensation award letter.
- Copies of support orders or checks, if you receive regular child support.

Earned Income. Earned income includes income from a job or self-employment. You must send us proof of income (as listed above). Send copies – we cannot send originals back to you. Add an additional sheet of paper for additional earned incomes.

Income #1:

Whose income is this?		Income Source:		Do you still have this income?	
Employer/Business Name:		How much income? (Amount before taxes)	\$	How often is this amount received? (weekly, every two weeks, monthly, or yearly)	

Income #2:

Whose income is this?		Income Source:		Do you still have this income?	
Employer/Business Name:		How much income? (Amount before taxes)	\$	How often is this amount received? (weekly, every two weeks, monthly, or yearly)	

Income #3:

Whose income is this?		Income Source:		Do you still have this income?	
Employer/Business Name:		How much income? (Amount before taxes)	\$	How often is this amount received? (weekly, every two weeks, monthly, or yearly)	

Income #4:

Whose income is this?		Income Source:		Do you still have this income?	
Employer/Business Name:		How much income? (Amount before taxes)	\$	How often is this amount received? (weekly, every two weeks, monthly, or yearly)	

Unearned Income. Unearned income sources include income from retirement/pension plans, worker's compensation, social security, child support payments, and unemployment benefits. You must send us proof of income (as listed above). Send copies – we cannot send originals back to you. Add an additional sheet of paper for additional earned incomes.

Whose income is this?	Income Source	Do you still have this income?	How much? (Amount before taxes)	How often is this amount received? (weekly, every two weeks, monthly, or yearly)

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4. Dependent Care Expenses Does anyone in the household pay for child OR adult daycare for another member of the household? If YES, complete this section for each person in care.

Who is in care?	How much do you pay each month?	How many months each year?	Who in the home pays for this care?	Do you still have this expense?
				YES <input type="checkbox"/> No <input type="checkbox"/>
				YES <input type="checkbox"/> No <input type="checkbox"/>
				YES <input type="checkbox"/> No <input type="checkbox"/>

5. Health Insurance Coverage Does anyone in the household have a current health insurance card that is **not** CHIP that they use for healthcare? If YES, complete this section.

Policy Information:	Name on Policy:		Insurance Company Name:	
	Policy Number:	Group Number/Name:	When did the policy start?	When did/will the policy end?
Who is Covered?	Name:	Name: :	Name: :	Name:
Who is Covered?	Name	Name:	Name:	
What is covered?				

6. Pregnancy Is anyone in the household pregnant? If YES, complete this section.

Name	Due Date

7. Disability Does anyone in the household have a permanent disability? If YES, complete this section.

Name	Type of Disability

Confirmation (Signature Required to Complete this Renewal)

- You must **sign below** if you are using this paper form to renew your family's health benefits. Remember to also send copies of your proof of income. Please use the return envelope provided.
- If you renew over the phone or online through COMPASS, you must send us copies of your proof of income by «**Renewal_Date**». Please write your E-form number (provided by the phone representative or by COMPASS) on all of your documents.

I hereby certify that I have read and fully understand this form and have answered the questions truthfully. I understand that if some or all of my children do not qualify for CHIP, they may qualify for Medical Assistance. If this is the case, I will allow CHIP to give my name and the information on this form to the Department of Public Welfare.

SIGNATURE: _____

DATE: _____