206-323-2834
1-800-945-4256
ehip@ehip.org
Fax: 206-323-0158

Complete this form ONLY if you need assistance enrolling into insurance or want the Evergreen Health Insurance Program (EHIP) to pay your insurance premiums.

**EHIP can pay for these types of plans:**
Group / Employer Sponsored Insurance (ESI)
Individual Plans
Medicare Part D (PDP)
Medicare Advantage + Prescription Drug Plans (MA-PD)
**Silver or Gold** Qualified Health Plan in the Exchange (QHP)
Healthcare for Workers with Disabilities (HWD)
Active COBRA Plan

**EHIP cannot pay for these types of plans:**
Medicare Part B
Health Savings Accounts (HSA)
**Bronze** Qualified Health Plan in the Exchange (QHP)
Stand Alone Dental or Vision
New COBRA Elections

## NEW ENROLLMENT / NEW PAYABLE

| **First Name:** | **Last Name:** | **M.I.:** |
|---|---|---|
| **EIP ID:** | **Date of Birth:** ___/___/____ | |

**HAS YOUR ADDRESS OR PHONE NUMBER CHANGED IN THE PAST SIX MONTHS?** ☐ Yes ☐ No

New Address: _____
(Street, unit number) (City, State, Zip)

New Phone: ( _____ ) _____
Area Code

**HAVE YOU USED TOBACCO PRODUCTS IN THE LAST 6 MONTHS?** ☐ Yes ☐ No

☐ Check here if you do not have insurance yet and need assistance with enrollment and payment. Please proceed to the required sections on the back.

**If you are already enrolled in insurance, please provide the information below for the plan you want EHIP to pay for:**

| **Insurance Company** | **Plan Name** |
|---|---|

**What type of insurance plan is this?**
☐ Medicare Prescription Drug Plan (PDP)
☐ Medicare Advantage Prescription Drug Plan (MA-PD)
☐ Individual Plan (Outside the Exchange)
☐ Qualified Health Plan in the Exchange (QHP)
☐ Group / Employer Sponsored Insurance (ESI)
☐ Healthcare for Workers with Disabilities (HWD)
☐ Active COBRA Plan
☐ I don't know

| **Who are the premium checks made out to?** | **Your Policy Number** | | |
|---|---|---|---|
| **Mailing Address (for premium)** | **City** | **State** | **Zip** |
| **Company Telephone Number** | **Contact Person** | | |
| **Monthly Premium Amount** / **Annual Deductible** | **Next Premium Due Date** | | |

**This Plan Has:** ☐ Dental Benefits ☐ Vision Benefits

**Please complete the Required Authorization on the back →**

## Authorization to Obtain Insurance Information (REQUIRED)

**Client Name: _____ Date of Birth: _____**

**Social Security or Subscriber ID number: _____**

**Name of Insurance Company / COBRA Administrator / Employer that Evergreen will be paying ("Insurer"):**

_____

Release of Information. I authorize the Insurer named above, and its health plan administrator(s), to discuss or release Personal Health Information (PHI) or Personal Financial Information (PFI) to the Evergreen Health Insurance Program ("EHIP") for the limited purpose of making or coordinating payment for my health plan benefits, and verifying eligibility for EHIP's services. I understand that Insurer may disclose PHI or PFI regarding the following information: eligibility, billing, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals, and complaints about my health insurance coverage through the Insurer.

I also understand that PHI and PFI disclosed to EHIP may no longer be protected by federal privacy laws, and may be subject to re-disclosure by EHIP, subject to the conditions of any authorization I have given to EHIP.

Your rights with respect to this Authorization:

- You are not required to sign this authorization in order to receive health care benefits from the Insurer, but **if you do not provide this authorization to EHIP, it may not be able to pay premiums on your behalf**.
- You may revoke this authorization at any time by notifying EHIP and the Insurer, but the revocation will not apply to actions that the Insurer has already taken based on your authorization. After such revocation you will no longer be eligible for EHIP services. Your revocation must be in writing and signed by you.
- You have the right to inspect and copy the protected health information covered by this authorization.
- This authorization will remain in effect until 6 months after termination of benefits under the Insurer, unless earlier revoked.

Signature and Authorization. I, the undersigned, do hereby swear that I am the above-mentioned Client, or an authorized legal representative of the above-mentioned Client. I have read and understand the content of this Authorization Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

X _____ _____

Signature of Client / Legal Representative — Today's Date (mm/dd/yyyy)

_____ _____

Printed Name of Legal Representative — Legal Representative's Relationship to Client

## Authorization for Evergreen Health Insurance Program (EHIP) to Provide Services (REQUIRED)

While I am eligible and enrolled for premium assistance from EHIP, I agree to allow EHIP to make insurance premium payments to my insurance company / COBRA Administrator / Employer ("Insurer") on my behalf, and to provided any necessary updates to Insurer about my coverage or eligibility (for example, if I move, EHIP may notify the Insurer of my new address and request that the Insurer update their records).

I understand that if I lose my eligibility to receive services from EHIP (for example, because I no longer reside in Washington State), EHIP will notify the Insurer that EHIP will no longer be making premium payments on my behalf, and provide the reason for the discontinuation. **I understand that the Insurer may discontinue my health insurance coverage when it receives this notice.**

If EHIP has stopped making premium payments on my behalf because I lost eligibility, and I later become eligible again for premium assistance, I authorize EHIP to resume payment, and , if necessary, to request that the Insurer reinstate my health insurance coverage. I understand that reinstatement is subject to the Insurer's policies, and that it might be necessary for me to reapply to the insurer in order to resume coverage.

X _____ _____

Signature of Client / Legal Representative — Today's Date (mm/dd/yyyy)

_____ _____

Printed Name of Legal Representative — Legal Representative's Relationship to Client