Iowa Department of Human Services

Employer Verification of Insurance Coverage

Directions: The employee must sign and date this form and then give it to the employer to complete. The employer completes and returns this form ONLY if the employee/dependents are CURRENTLY enrolled or have been accepted for coverage in the employer's group health insurance plan. Thank you.

Employee Permission to Release Information

I give my employer permission to share information about my employer health insurance benefits. I will not take legal action against them for sharing this information. This information may be discussed either verbally or in writing. This permission will end thirteen months from the date of my signature. I understand that I have the right to notify my employer if I want the permission to end at an earlier date.

Name of Employee (Please print)	SSN
Signature of Employee **X**	Date

The remainder of this form is to be completed by the employer.

1. **List ALL persons covered under the plan and** enter the **effective date** of their Medical and Rx coverage:

Covered Person's Name	Date of Birth	Effective Date Medical and Rx
Start with -		

2. Provide the date the next payroll period starts _____/_____/_____ and ends on _____/_____/_____ with pay date on _____/_____/_____. The health insurance premium deducted on this pay date is for the time period _____/_____/_____ to _____/_____/_____.

3. Circle the day of the week the employee gets paid: M T W Th F Sa Su

4. Check the frequency of payroll deduction for insurance:
   Weekly 48 ❑ Weekly 52 ❑ Bimonthly 24 ❑ Biweekly 26 ❑
   Semi Monthly ❑ on (dates): _____ & _____ Monthly ❑ indicate date each month: _____

5. What is the **employee's** cost of insurance **per pay check** for: Medical $_____ Rx $_____
   ** If cafeteria or flex dollars are used to reduce the premiums, please attach proof as to how they are applied.

6. Is this a High-Deductible Health Plan (per Section 223(c)(2) of the Internal Revenue Code)? ☐ Yes ☐ No

Continue on back of this page **Over** ⟶

CHOOSE ONE PAYMENT OPTION

Questions or need help? Toll Free 1-888-346-9562 Local (515) 974-3282 Fax (515) 725-0725
HIPP Unit, PO Box 36476, Des Moines, IA 50315-9907

7. Who do you want the Department of Human Services, Health Insurance Premium Payment (HIPP) program to reimburse for the health insurance premiums?

   The employee ❑ or The employer ❑ If the employer in lieu of a payroll deduction, list the address where to send payments below:

   If paying the employer directly, what is the date the next insurance premium is due? _____

Health Insurance Carrier Information	Prescription Carrier Information
Name: _____	Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Dental Insurance Carrier Information	**Vision Insurance Carrier Information**
Name: _____	Name: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____

Employer Name: _____

Address/City/State/Zip: _____

Employer's Website: _____

On what date are group policy premiums renewed each year? _____

Employer Information			
Name of Employer Representative Completing this Form (please print)			
Signature of Employer Representative			
Date	Phone number	Email address	Employer Fed Tax ID No.