Louisiana Health Insurance Program

P.O. Box 66913, Baton Rouge, LA 70896
(888) 647-1269 (toll free phone) / (225) 424-1799 (phone) / (225) 927-1267 (fax)

Date_____

Dear Human Resource Department:

The Louisiana Health Insurance Program (HIP) of the Office of Public Health offers assistance with the payment of health insurance premiums to individuals who meet specific medical and financial criteria.

_____ has been approved to participate in this program. HIP will only pay the employee's portion of their health, dental and/or vision insurance premium. HIP does not cover the company's portion of the premium. Other family members should not be included on the premium statement as we do not assist with family coverage. HIP ***CANNOT*** reimburse the employee for any premiums deducted from their paycheck.

Please complete the bottom portion of this letter acknowledging that you are aware of the person listed above, aware of his/her participation in HIP, and your company is willing to receive a third party payment on his/her behalf. If you should have any further questions, please contact HIP at 225-424-1799 or toll free at 1-888-647-1269. **Please select one:**

☐ **Yes,** our company will accept your premium payment on the employee's behalf. (Please complete the information listed below and sign).

☐ **No,** our company will NOT accept premium payments from the Health Insurance program (skip questions and sign).

Please complete this section and return to HIP by fax at (225) 927-1267 or by mail at address above. **If the employee has one or more additional insurance policies through your company (ex: a separate dental policy), for which you agree to accept payment, please fill out the section(s) on the next page.**

1. Who is the best person to contact if HIP has questions about the employee's insurance premium payment?	2. What is the best phone number to reach the contact person listed in question 1?	
3. Employer's Name (Who should the premium check be made out to?)		
4. Employer's Street Address (Where should the premium check be sent?)		
5. City	6. State	7. ZIP Code
8. Insurance Company & Plan Name (Example: Aetna/Max 1500)	9. Type of Policy (check all that apply) ☐ Health ☐ Dental ☐ Vision	
10. Member ID / Policy #	11. Group # (if applicable)	
12. Policy Start Date (MM/DD/YYYY)	13. Policy End Date (MM/DD/YYYY)	
14. What is the employee's portion of the insurance premium amount? $ _____ ☐ Check if this portion is a partial amount of a larger total premium, i.e. shared with employer/family member	15. How often should the premium payment be received? ☐ Monthly ☐ Quarterly ☐ Semi-Annually (twice a year)	
16. By what date should the next premium check be received by your office? (MM/DD/YYYY)	17. What day of the month do all future premium checks need to be received by your office? (Example: 15th)	

Signature_____**Date**_____

Additional Insurance Policy #1

18. Insurance Company & Plan Name (Example: Aetna/Max 1500)	19. Type of Policy (check all that apply) ☐ Health ☐ Dental ☐ Vision
20. Member ID / Policy #	21. Group # (if applicable)
22. Policy Start Date (MM/DD/YYYY)	23. Policy End Date (MM/DD/YYYY)
24. What is the employee's portion of the insurance premium amount? $_____ ☐ Check if this portion is a partial amount of a larger total premium, i.e. shared with employer/family member	25. How often should the premium payment be received? ☐ Monthly ☐ Quarterly ☐ Semi-Annually (twice a year)
26. By what date should the next premium check be received by your office? (MM/DD/YYYY)	27. What day of the month do all future premium checks need to be received by your office? (Example: 15th)

Signature_____Date_____

Additional Insurance Policy #2

28. Insurance Company & Plan Name (Example: Aetna/Max 1500)	29. Type of Policy (check all that apply) ☐ Health ☐ Dental ☐ Vision
30. Member ID / Policy #	31. Group # (if applicable)
32. Policy Start Date (MM/DD/YYYY)	33. Policy End Date (MM/DD/YYYY)
34. What is the employee's portion of the insurance premium amount? $_____ ☐ Check if this portion is a partial amount of a larger total premium, i.e. shared with employer/family member	35. How often should the premium payment be received? ☐ Monthly ☐ Quarterly ☐ Semi-Annually (twice a year)
36. By what date should the next premium check be received by your office? (MM/DD/YYYY)	37. What day of the month do all future premium checks need to be received by your office? (Example: 15th)

Signature_____Date_____