VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Immigrant Health Insurance Plan Application

Contact us:

PHONE: Call Customer Service at 1-855-899-9600

ONLINE: dvha.vermont.gov/apply

IN PERSON: There is someone who can help in your area.
info.healthconnect.vermont.gov/information/communitypartners/assisters, or call 1-855-899-9600

TTY/RELAY: If you are deaf, hard of hearing, or have a speech disability, dial 711.

MAIL: Vermont Health Connect, 280 State Drive - NOB1 South
Waterbury, VT 05671-8100

Use this application for	• **Immigrant Health Insurance Plan (IHIP)** – for children under age 19 and pregnant people. To qualify, they must have an immigration status that only lets them get Emergency Medicaid. This may include immigrants who: ○ Entered the U.S. legally but broke the terms of their status *(Example: over-stayed a visa)*; ○ Entered the U.S. without documents or permission; ○ Some temporary non-immigrants, including farm workers; ○ Deferred Action for Childhood Arrivals (DACA); ○ Are waiting for action from an immigration agency on a formal application; ○ Are asylum-seekers who have not yet submitted an application; Or who have not yet been granted employment authorization; Or if under age 14 have had an application pending for less than 180 days.
Do NOT use this application for:	• Reported changes. To report changes to your information, call Customer Service at 1-855-899-9600. Or mail your changes to: *Vermont Health Connect, 280 State Drive - NOB 1 South, Waterbury, VT 05671-8100* • Medicaid (including Emergency Medicaid), Pharmacy programs (Vpharm and Healthy Vermonters) or Medicare Savings Programs. If you want to apply for any of these programs, call Customer Service at 1-855-899-9600.
Why we need this information	We ask about income and other information to determine what coverage you qualify for. Income of some household members may count even if they are not applying. We will keep all the information you give us private and secure, as required by law. We will NOT share your information with the United States government.
Be sure to have	• Employer and income information for everyone in your family who lives with you • Proof of identity, age and state residency for anyone applying • See page 5

Interpretation services are available

(العربية) 1-855-899-9600 اتصل بالرقم. إذا كنت تتحدث لغة أخرى غير اللغة الإنجليزية ، فستوفر لك خدمات مساعدة اللغة مجاناً)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-899-9600。(繁體中文)
Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-899-9600 (Deutsch)
Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-899-9600 (Español)
Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-899-9600 (Français)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-899-9600 まで、お電話にてご連絡ください。(日本語)
In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-899-9600 (Italiano)
तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-899-9600 । (नेपाली)
Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-899-9600 (Oroomiffa)
Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-899-9600 (Português)
Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-899-9600 (Русский)
Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-899-9600 (Srpsko-hrvatski)
Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-899-9600 (Tagalog)
ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-899-9600 (ภาษาไทย)
Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-899-9600 (Tiếng Việt)

You may keep this page for future reference.

How Should You Apply for the Immigrant Health Insurance Plan (IHIP)?

There are 2 ways to apply for the Immigrant Health Insurance Plan (IHIP):

1. Medicaid application (205ALLMED)
2. IHIP application (205IHIP)

Do you have questions? Not sure which application is best for you?

Then call the Office of the Health Care Advocate at Vermont Legal Aid for free at **1-800-917-7787**. They can help you.

Are you pregnant?

1. If you apply using the Medicaid application:
   - If you meet the rules, you will get <u>both</u> Emergency Medicaid and IHIP.
     - Emergency Medicaid will pay for your labor and delivery.
     - IHIP will pay for your other health care needs.
   - We will put your baby on Medicaid as soon as they are born. You won't have to apply.
   - The baby will get Medicaid for 12 months after they are born. This is true even if your income goes up. But they must keep living in Vermont.
   - We share your health insurance information with CMS (Centers for Medicare and Medicaid Services). CMS helps run Medicaid. The law says we and CMS can only share your information for Medicaid reasons. Information **CANNOT** be shared with federal immigration authorities like ICE.
2. If you apply using the IHIP application:
   - If you meet the rules, you will only get IHIP.
     - IHIP will pay for labor and delivery.
     - IHIP will pay for your other health care needs.
   - Your baby won't get Medicaid as soon as they are born. You will have to apply. We have 45 days to decide if they get it.
   - Your health information can't be shared with <u>any</u> part of federal government.

Are you under age 19?

- You can apply for IHIP using the Medicaid application OR the IHIP application. They both pay for the same things.
- Are you using the IHIP application? Your health information can't be shared with <u>any</u> part of federal government.
- Are you using the Medicaid application? Your health information can <u>only</u> be shared with CMS (Centers for Medicare and Medicaid Services). CMS helps run Medicaid. The law says we and CMS can only share your information for Medicaid reasons. Information **CANNOT** be shared with federal immigration authorities like ICE.

Do you have others in your household who are US citizens? Or do they have eligible immigration status for Medicaid?

- You can use **one** Medicaid application to apply for yourself and others you live with.
- Did you apply using the IHIP application? Are others who live with you citizens or have eligible immigrant status? You must use the Medicaid application to apply for them.

How to apply using the Medicaid application:

- **The best way is by mail:** Call Customer Service at **1-855-899-9600**. Ask them to mail you a paper copy of the 205ALLMED. When you get the application, fill it out and send it to:
  Vermont Health Connect
  280 State Drive, NOB1 South
  Waterbury, VT 05671-8100
- **By phone**: Call Customer Service at **1-855-899-9600.**
- **Online:** <u>VermontHealthConnect.gov</u> or
- **In person:** You can get in-person help from an Assister. To find one near you, go to **<u>info.healthconnect.vermont.gov/find</u>** on the internet. Or call VHC Customer Support at **1-855- 899-9600.**

How to apply using the IHIP application:

- **Send us the 205IHIP by mail.** Call Customer Service at **1-855-899-9600**. Ask them to mail you a paper copy of the 205IHIP. When you get the application, fill it out and send it to:
  Vermont Health Connect
  280 State Drive, NOB1 South
  Waterbury, VT 05671-8100
- **In person:** You can get in-person help from an Assister. To find one in your area, go to **<u>info.healthconnect.vermont.gov/find</u>** on the internet. Or call VHC Customer Support at **1-855- 899-9600.**

Your Rights and Responsibilities

Everyone applying has these rights and responsibilities.
Need a **large print copy** of this? Call Customer Service at *1-855-899-9600*.

If You Don't Speak or Read English.
We will give you free language services. This means:

- Interpreters on the phone
- Information written in your language

If you need this, call Customer Service at **1-855-899-9600**. If you don't get the language services you need, you can file a complaint. To find out how, see **What to Do if You Think You Are Being Discriminated Against** on this page.

Right to Information about Medicaid. If you are pregnant, you may want to apply for Medicaid before you give birth. If you are approved, then your newborn will be put on Medicaid right away. In most cases, they will stay on it for a year. **But you must get approved for Emergency Medicaid to get this.** Ask us if applying for Medicaid might help other people you live with. Some children can get Immigrant Health Insurance Plan (IHIP), and some can get Medicaid. Apply for all of your children.

Right to Apply and Get a Decision in 45 Days. It may take longer if you cause a delay. What if it takes more than 45 days? Call Customer Service at **1-855-899-9600** for more information or to file an appeal. Tell them you applied for IHIP.

Do You Disagree with a Decision We Made? You Can Appeal. An appeal means asking for a State fair hearing before the Human Services Board. Look at the notice of decision we sent to you to find out more about your right to appeal. You must appeal **within 90 days**. The 90 days start from the date on your letter.

How long do we have to answer your appeal? In most cases, we must send a final decision on your appeal within 90 days. The 90 days start when you appeal. To appeal, call Customer Service at **1-855-899-9600.** Tell them you applied for, or are on, IHIP. You may also write to the Human Services Board, 120 State Street, Montpelier, VT 05620-4301.

You may be able to get free legal help. Call the Health Care Advocate at Vermont Legal Aid **at 1-800-917-7787. OR** go to **https://vtlawhelp.org/ health** on the internet.

Rights of People with Disabilities. Do you have a physical, mental, or learning condition? Does it make it hard to do things we ask you to do? We can make changes to help you.

The Americans with Disabilities Act (ADA) and Vermont law say that we may have to make changes to our rules. The changes are called "reasonable accommodations." The changes help people with disabilities apply for and keep health insurance. Here are examples of changes we can make:

- Give you more time
- Help you get the proof you need to give us
- Send notices with a larger print

If you need this, call Customer Service at **1-855-899-9600.** Tell them you are on IHIP.

Right to be Helped by Others. Another person can help you apply and do other things. We can also send your notices and other documents to someone else. If you want this, fill out Appendix A.

What to Do if You Think You Are Being Discriminated Against. We can't treat you differently because of race, color, national origin, sex, or age. We can't treat you differently because of your sexual orientation, gender identity, or disability. What if we don't give you language or disability related services you need? It may be discrimination.

Do you think that we have discriminated against you? Call Customer Service at **1-855-899-9600**. Tell them you are on IHIP. You can also file a complaint with our Civil Rights Coordinator at **(802) 241-0454.**

Information for Non-Citizens. Are you getting health insurance through IHIP? It will **not** change the immigration status of you or someone who lives with you. We will NOT share any information about your IHIP application or health insurance with the U.S. government. **Have questions or concerns?** You may get **FREE** legal help by calling the Health Care Advocate at Vermont Legal Aid at **1-800-917-7787. OR** go to **https://vtlawhelp.org/health** on the internet.

Right to Have Your Information Kept Secret. Information about your IHIP application and health insurance is private and protected by law. We **won't** share any information about you with the U.S. government. We **won't** share your information with anyone else unless:

- It is directly connected to running IHIP **or**
- It is required by law or a court order **or**
- You tell us we can.

How We Use Your Information. We will use your information to see if you meet the rules for IHIP. We will also use it to help pay for care and other legal reasons.

We may contact public and private agencies. We will **NOT** contact the U. S. government. What if the information you give us does not match what you told us? We may ask you to send us proof.

Right to See Your Case File. Tell us if you want to see your case file. Call Customer Service at **1-855-899-9600.** Tell them you are on IHIP.

You must tell us within 10 days IF:

- Your address, phone, or email changes
- Your income changes
- Who lives with you changes
- You get pregnant
- Your immigration status changes
- You get other health insurance
- You move out of state

Call Customer Service at **1-855-899-9600** to report changes. Tell them you are on IHIP.

You Must Give Us Information We Ask For. We decide if you meet the rules to get IHIP. You must give us information that we need to decide. This includes you sending us documents we ask for. If you don't, we may have to turn you down or stop your IHIP.

Don't Lie to Get or Keep IHIP or Help Someone Else Get or Keep it. This is also true for any member of your household. What if you do it and are found guilty? Penalties may include up to 3 years in prison or a fine. (42 U.S.C. §1320a-7b; 33 V.S.A. §§141, 143)

Agreement to Release Medical Records. You agree that your medical records may be read, used and shown to others in some situations. This lets these groups share your records:

- Health care providers
- Department of Vermont Health Access
- The Department's contractors and grantees

They can share your records to:

- Manage state health care programs or
- When a hospital, health care provider, mental health provider, or pharmacy needs your medical records. This includes:
  - Provider and prescription information for your treatment
  - Payment of your treatment
  - Health care operations.

Have you been in a drug or alcohol treatment program? You agree to let them tell us what prescription drugs you got in their program IF this is needed for your treatment.

Can you take back your consent to the release of your medical records? Yes, say that in writing and mail it to:

DVHA Deputy Commissioner
280 State Drive, NOB1 South
Waterbury, VT 05671-1010

Agreement to Let Us Get Money From Third Parties. You give us the right to try and get any money for your health care costs from:

- Other health insurance
- Legal settlements or
- Other third parties

This applies to you and anyone in your household who gets IHIP.

Need help?

Visit **dvha.vermont.gov/apply**
or call Customer Service at
1-855-899-9600.

For TTY/relay services, dial **711**.
Tell them you are on IHIP.

Visit **dvha.vermont.gov/apply** or call Customer Service for a copy of your IHIP rights and responsibilities.

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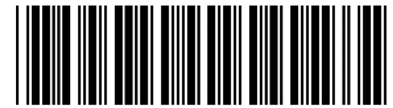
Immigrant Health Insurance Plan Application



1 Tell us about yourself

We ask for this information so that we can contact you about this application.

Name *(first, middle, last)* | Social Security Number *(optional)* | Date of Birth *(mm/dd/yyyy)*

Home address *(leave blank if you do not have one)*

City | State | Zip code

Mailing address *(if different from home address)*

Phone number *(if you have one)* | Email address *(if you have one)*

If we call you, what language should we use?

2 Tell us about your family

List yourself and the members of your immediate family who live with you. Include your spouse and your children under age 19. Include any full-time students under age 21, if they live with you. Do not list other relatives or friends even if they live with you.

Name *(first, middle, last)*	Sex	Date of birth *(dd/mm/yyyy)*	Relationship to you	Applying for Immigrant Health Insurance Plan? *(Yes or No)*	*Answer for family members who are applying. If a person is not applying, you don't have to answer these questions for them.* Social Security Number *(optional)*	Are you a U.S. Citizen or U.S. National? (Yes or No)	Do you live in the State of Vermont? (Yes or No)
(Same as above)	☐ Male ☐ Female		(Self)	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
	☐ Male ☐ Female			☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
	☐ Male ☐ Female			☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
	☐ Male ☐ Female			☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
	☐ Male ☐ Female			☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
	☐ Male ☐ Female			☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

3 Other questions

Answer these questions for yourself and your family members listed in Section 2. Your answers make it easier to see if you and family members meet the rules.

Is anyone pregnant, even if they are not applying for the Immigrant Health Insurance Plan? ☐ Yes ☐ No

If yes, who?____

How many babies are expected?____________________ Estimated due date:____________________

Does anyone who is applying for Immigrant Health Insurance Plan have other health insurance *(Examples: Medicaid, Medicare, etc.)*? ☐ Yes ☐ No

If yes, who?____

Name of insurance plan:____

4 Tell us about your family's income

Write the total income before taxes are taken out. Do this for all family members listed in Section 2.

Employment *(Includes Temporary/Contract Jobs)*

Is anyone in your household employed? ☐ No If YES, list below.

→ Include anyone who worked in the last 30 days or expects to work next month

Who?	Employer Name	How often paid?	Avg. Hrs/Wk	Wages/Tips (Before Tax)
				$ **per** *Hr Wk 2Wks 2x/Mo Mo Yr*
				$ **per** *Hr Wk 2Wks 2x/Mo Mo Yr*

Self-Employment

Is anyone in your household self-employed? ☐ No If YES, list below.

Who is self-employed?	Type of Work	Monthly Income *(Amount after Expenses)*
		$
		$

Additional Income

Does anyone in your household have additional income? ☐ No If YES, list below.

☐ Unemployment ☐ Alimony/Spousal Support ☐ Social Security ☐ Pension/Retirement ☐ Rental Income ☐ Interest/Dividends

☐ Other: *Tribal Income/Benefits, Short Term/Long Term Disability, Gambling/Lottery winnings*

Who has additional income?	Type of income	Amount and frequency of income
		$ **per** *Hr Wk 2Wks 2x/Mo Mo Yr*
		$ **per** *Hr Wk 2Wks 2x/Mo Mo Yr*

Deductions

List any of the deductions you're able to claim from the 'Adjustments to Income' section of schedule 1 of your **1040 federal income tax return**. *Please do not include any itemized deductions from schedule A.*

NOTE: You should not include a cost that you already deducted from your self-employment net income.

- ☐ None
- ☐ Alimony paid $____________ How often?__________ Was the agreement signed after 2018? ☐Yes ☐No
- ☐ Student loan interest $____________ How often?__________
- ☐ Other deductions $____________ How often?__________ Type(s):______________________________

Yearly Income

Does anyone's income change from month to month? ☐ No If YES, list below.

Whose income changes month to month?	Total Estimated Income This Year

Did you list no income on this application? Then tell us how your daily living expenses are paid. *(If you don't, your application may take longer):*

____

____

____

____

5 Tell us if you have any unpaid medical bills

Do you have medical/dental expenses from the last 3 months? We may be able to pay those expenses.

Do you want to apply for help with medical/dental expenses from the last 3 months?

☐ No If YES, list below.

Who has the medical bills? **Tell us which month(s) you have medical bills from.**

Name	Month	Month 2	Month 3
Example: Self	July	August	September

Were you living in Vermont in each month? If NO, when did you begin living in Vermont?____________________

Was your income the same in all 3 months above? ☐ Yes ☐ No

6 SIGN THIS APPLICATION

Immigration Status Statement – The Immigrant Health Insurance Plan is ONLY for children under age 19 and pregnant people. They must have an immigration status for which they can only get Emergency Medicaid. Anyone with an immigration status that they know is eligible for full Medicaid (NOT just Emergency Medicaid) should NOT use this application.

By signing below, I swear that I have read and understand the Immigration Status Statement above.

The person listed in STEP 1 should sign this application. Are you that person's Authorized Representative? You may sign for them as long as they signed Appendix A (on page 6). Are you the *power of attorney or legal guardian* for the person listed in STEP 1? Submit proof with this application.

By signing this application, you agree:

- I have read and understand my rights and responsibilities. They are described on pages iii and iv of this application.
- I am signing this application under penalty of perjury. That means I told the truth and have not lied on purpose. If I lied, I could pay a fine or go to prison.

Are you signing this application because the applicant is a minor child or incapacitated adult? Incapacitated adult means they can't do this for themselves. Then, you agree to the following:

- I am giving information to get and keep health care benefits for the applicant. This is because the applicant is a minor child, or has a physical or mental condition that keeps them from doing it for themselves.
- I will give the best information I know concerning the applicant's situation.
- I understand that I can't keep back information or knowingly misrepresent the facts. If I do, I may have to pay a fine or go to prison. I agree to notify Department of Vermont Health Access immediately if I learn of any change in the applicant's situation.

Signature *(applicant, or person signing on behalf of applicant)* X	**Date** *(mm/dd/yyyy)*

You are not done yet. See next page for what proof you need to send with this application.

Are you signing because the applicant is a minor child or incapacitated adult? Give us the information we ask for below. We may need to reach you for questions about the application.

Person signing on behalf of the applicant *(first, middle, last name & suffix (Jr., Sr., III, etc.))*			
Agency name *(if applicable)*			Phone number ( ) –
Street address/PO Box	City/Town	State	ZIP code

Women, Infants, and Children (WIC): The Special Supplemental Nutrition Program for Women, Infants, and Children offers health screening, nutrition education, and food for pregnant women, nursing women, and children under 5. To learn more about this program, call toll free 1-800-464-4343 or visit WIC's homepage at healthvermont.gov/wic.

Voter Registration: If you are not registered to vote where you live now, would you like a voter registration application? ☐ Yes ☐ No

If you do not check either box, you will be considered to have decided not to register to vote at this time. Applying to register or declining to register to vote will not affect your eligibility for benefits or amount granted to you by this agency. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of State's Office at 128 State Street, Montpelier, VT 05633-1101, or call 1-802-828-2363.

Did you get help with this application? You may need to fill out **Appendix A**: Tell us who is helping you with this application

Send Us Proof

We need to check certain information you give us. We must make sure you meet the rules for the Immigrant Health Insurance Plan. For **each person applying**, we need proof of identity, age, income and that they live in Vermont. To speed up the processing of your application, send us copies of the proof with your application. If you don't, we will send you a letter asking for it.

Proof that you and others applying **live in Vermont**:

1. Two pieces of mail with name and current street address (This is only if you get mail at the street address); **OR**
2. What if you don't get mail at the street address? We need any two of the following which show street address:
    a. Rental or lease agreements
    b. Home utility bills, including cell phone bills (the bill must list service address)
    c. Vermont driver's license
    d. Insurance documents, including medical, life, home, rental, and vehicle
    e. A property tax bill or statement with physical location; **OR**
3. What if you live with others and get no mail at a street address? You can give us a signed affidavit saying you live at a certain street address. You must also send in one of the papers under #2 listed above.

Proof of **Identity** and **Age** may include the following ***If you have already sent us this, you don't need to do it again***:

1. Driver's license or identification card issued by government (federal/state/local); **OR**
2. School identification card; **OR**
3. A clinic, doctor, hospital or school record. This includes preschool or day care records (for children under age 19); **OR**
4. Two documents with matching information that proves identity, such as:
    a. Employer ID card
    b. High school and college diplomas
    c. Marriage certificates
    d. Divorce decrees
    e. Property deeds or titles; **OR**
5. What if you don't have any of these papers? You may submit a signed affidavit, under penalty of perjury, by a person who can swear who you are. It must say that lying on purpose will mean a fine or prison. The paper must contain your name and other identifying information. It must include your name, age, sex, race, height, weight, eye color, and address.

Proof of **income** - below are common documents for different income types:

1. Letter from employer; **OR**
2. Most recent tax return, including 1040; **OR**
3. Complete tax return including all forms and schedules, if self-employed; **OR**
4. Wages and tax statement (W2 form); **OR**
5. Pay stubs; **OR**
6. Agricultural (farm) income certificate; **OR**
7. Most recent quarterly or year-to-date profit and loss statement

Need more examples of documents you can use to prove income and identity? Visit:

dvha.vermont.gov/information-for-non-citizens for Immigrant Health Insurance Plan.

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APPENDIX A Tell Us Who is Helping You with This Application

PERSON 1 Information

First name, middle name, last name & suffix *(Jr., Sr., III, etc.)*	Last 4 digits of your SSN __ __ __ __

You Can Choose an Authorized Representative

You can give a trusted person permission to talk about this application with us. They can see your information, and act for you on matters related to this application. This includes getting information about your application and signing your application for you. This person is called an Authorized Representative. You decide if you want an authorized representative.

If you choose to have one:

- It will last while you get IHIP. It stops if you ask us to change or stop it.
- We aren't responsible for what an authorized representative does with your information (like tell others).
- Ask us if you want a copy of this form.

If you choose not to have one:

- It won't change if you meet the rules or what is covered.
- We won't release your information unless the law allows it.

1. Name of Authorized Representative *(first name, middle name, last name & suffix (Jr., Sr., III, etc.))*

2. Address		3. Apartment or suite number
4. City/Town	5. State	6. ZIP code
7. Phone number ( ) –		
8. Organization name (if applicable)	9. ID number (if applicable)	

By signing, you allow this person to sign your application. They can get information about your IHIP application and health insurance. They can act for you on some future Immigrant Health Insurance Plan matters.

10. Your signature	**11. Date** *(mm/dd/yyyy)*

You Can Choose an Alternate Reporter

You can give someone permission to only get copies of letters about your application. They can get information about coverage for yourself and others on the application. This person is called an Alternate Reporter. An Alternate Reporter **cannot** act for you or report changes for you. But they can help you understand the letters. They can remind you if we ask you for information.

1. Name of Alternate Reporter *(first name, middle name, last name & suffix (Jr., Sr., III, etc.))*

2. Address		3. Apartment or suite number
4. City/Town	5. State	6. ZIP code
7. Phone number ( ) –		
8. Organization name *(if applicable)*	9. ID number *(if applicable)*	

By signing, you let this person get copies of letters about your application. They can get information about coverage for yourself and others on this application. They can get all future Immigrant Health Insurance Plan information. This is only if they are within the scope of an alternate reporter.

10. Your signature	**11. Date** *(mm/dd/yyyy)*

To change or remove an Authorized Representative or Alternate Reporter, call Customer Service at 1-855-899-9600. (This will not affect information we've already shared)