Thank you for your interest in MaineCare’s Private Health Insurance Premium (PHIP) Benefit. The PHIP Benefit pays insurance premiums for MaineCare members who qualify. **Having the PHIP Benefit pay your private health insurance premium, will not make you lose MaineCare.**

**How do I find out if the PHIP Benefit can pay my insurance premium?**

- Fill out as much information as you can on the Employer and Insurance Information form (enclosed). Your employer may be able to help with this. If your insurance is not through an employer, please fill out the insurance information section.

- Send proof of the cost of the premium. A pay stub or an insurance premium bill will be proof.

- Ask your employer or your insurance company for a “Statement of Insurance Benefits”. This statement shows the coverage you have, at what percent it is provided, and your deductibles and co-pays. Send this along with your application.

- Fill out the W-9 form. We need this information in order to send you checks.

Send all of the information in the enclosed self-addressed envelope. If you have questions, feel free to contact our office.

Sincerely,

Benefits Administrator
1-800-977-6740
Fax: 287-9385
MaineCare Private Health Insurance Premium Benefit
(PHIP Benefit)

What is the MaineCare PHIP Benefit?
The PHIP Benefit pays private health insurance premiums for MaineCare members who qualify. You must already have health insurance or you must be able to get it. You may have health insurance through your job, or you may have an individual policy through an insurance company. MaineCare will not find health insurance for you.

How will the PHIP Benefit help me?
MaineCare will pay part or all of the monthly cost of your health insurance plan.

How does the premium get paid?
The PHIP Benefit will reimburse you directly with a check in the mail or direct deposit.

Can I have MaineCare and private health insurance at the same time?
Yes, even if you have private health insurance, you can qualify for MaineCare. The PHIP benefit is only for people who have MaineCare.

Directions for filling out the PHIP application:

Employer and Insurance Information Form. Please fill in all requested information on the form. Be sure you list the amount you pay for your policy and, if it is an employer plan, how often money is deducted from your paycheck. Please also note when open enrollment is so we know when to expect your costs to change. *We do not pay dental premiums, but still need to know if you have dental coverage.

W-9 Form. This form is to be filled out by the policy holder of the health insurance. Please fill in ONLY the policy holder’s name, address, social security number, signature and date. This form is not used for tax reporting services. Our Accounting department needs it in order to send you checks.

MaineCare Participants Form: This form is to tell us who in the family is covered or going to be covered by the private health insurance. Please list the names, relationship to the policy holder, and MaineCare ID# for each person.
PHIP APPLICATION
INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED
EMPLOYER AND INSURANCE INFORMATION

Date of open enrollment: ___________ If Katie Beckett eligible – KB Premium Amt ____________

Employee Name: ________________________ Employee SS#: ________________________
Employee Address: ________________________ Telephone Number ________________________
Employer Name: ________________________ Contact Person: ________________________
Employer Address: ________________________ Telephone number: ________________________

Medical Ins. Carrier Name: ________________________ Address: ________________________
Dental Ins. Carrier: ________________________ Dental Ins. Carrier Address: ________________________

*PLEASE ONLY SHOW HOW MUCH IS ACTUALLY BEING DEDUCTED FROM PAYCHECK

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Employee Cost</th>
<th>How Often Deducted</th>
<th>(Please X covered services)</th>
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</thead>
<tbody>
<tr>
<td>Single – Medical</td>
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<tr>
<td>Single – Dental</td>
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<td>Weekly ↓</td>
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<td>Employee w/Chrn -</td>
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<td>Medical</td>
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<td>Employee w/Chrn –</td>
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<td>Bi-Weekly ↓</td>
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<td>Dental</td>
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<td>Employee, Spouse -</td>
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<tr>
<td>Medical</td>
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<td>Please circle 50 or 52</td>
<td>Maj. Med/Comp. Plan</td>
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<tr>
<td>Employee &amp; Spouse –</td>
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<td>Dental</td>
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<tr>
<td>Family – Medical</td>
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<tr>
<td>Family – Dental</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Family – Medical
Family – Dental

Medical Deductibles:

Single: ________________________ Family: ________________________

Co-pay:

Enrolled: Medical Y N Enrolled: Dental Y N

PLEASE REPORT YOUR INSURANCE INFORMATION TO MEMBER SERVICES , 800-977-6740

Certificate # _______ Group # _______ Certificate # _______ Group # _______

Single
Employee w/Children
Employee w/Spouse
Family

Employee w/Spouse
Employee w/Spouse
Family
MaineCare Member Information

Policy Holder: __________________________________________________________
MaineCare ID# _______________________________________________________

MaineCare Member: _____________________________________________________
MaineCare ID # _______________________________________________________
Relationship to Policy Holder: __________________________________________

MaineCare Member: _____________________________________________________
MaineCare ID # _______________________________________________________
Relationship to Policy Holder: __________________________________________

MaineCare Member: _____________________________________________________
MaineCare ID # _______________________________________________________
Relationship to Policy Holder: __________________________________________

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MaineCare ID # _______________________________________________________
Relationship to Policy Holder: __________________________________________

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MaineCare ID # _______________________________________________________
Relationship to Policy Holder: __________________________________________

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MaineCare ID # _______________________________________________________
Relationship to Policy Holder: __________________________________________

MaineCare Member: _____________________________________________________
MaineCare ID # _______________________________________________________
Relationship to Policy Holder: __________________________________________

MaineCare Member: _____________________________________________________
MaineCare ID # _______________________________________________________
Relationship to Policy Holder: __________________________________________
Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Name (as shown on your income tax return):

Business name, if different from above:

Check appropriate box: [ ] Individual/Sole proprietor [ ] Corporation [ ] Partnership [ ] Other [ ] Exempt from backup withholding

Address (number, street, and apt. or suite no.)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. person (including a U.S. resident alien). Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, or contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Signature of U.S. person:

Date:

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

1. An individual who is a citizen or resident of the United States,

2. A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or

3. Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

1. The U.S. owner of a disregarded entity and not the entity,
STATE OF MAINE

ACTIVATION/CHANGE REQUEST FOR DIRECT DEPOSIT/EFT

To: OFFICE OF THE STATE CONTROLLER
ATTN: ACCOUNTING STAFF
14 STATE HOUSE STATION
AUGUSTA ME 04333-0014
Phone 207-626-8420  Fax 207-626-8447

We require you to submit a voided check or letter from your bank for account verification.

NEW CHANGE

*TIN is required – Employer ID No. or Social Security No.
Circle ONE

Payee's Name*

Contact Person's Name & Phone #: if different from Payee

Address of Payee

Email

TIN of Payee*

EIN  SSN

Vendor Code in the State's Accounting system.

Vendor Code can be provided by the State Agency.

Vendor Code

Include VC or VS

One Vendor Code (VC/VS) Number per form

I authorize the State of Maine to send DD/EFT payment detail to the email address included.

By signing and returning this document, you agree to the following statement:

I, the below signed, authorize you to electronically transfer payments to the account provided below. I've authorized the Agency to initiate credit entries and debit entries (only for the purposes of correcting an erroneous credit provided that, prior to the debit I've notified the Agency in writing of the reason) to my account at the below named financial institution. I agree to notify the Agency's office immediately upon discovery of any errors resulting from transactions under this authorization and to notify the Agency's office of any changes that may affect these instructions or the Agency's ability to rely upon them. This authorization may be canceled by me at any time by notifying the Agency in writing. In authorizing the above services to be provided to me, I've agreed to hold the Agency and the State of Maine harmless from any and all loss, cost, damage or expenses I've may suffer as the result of errors in deposits, credit entries or debit entries caused by persons who are not employees of the Agency or the State of Maine.

OLD Bank Info: This section is for Changes – For New bank set up, please skip to NEW section below.

Name on Account

Routing #

Name of Financial Institution

Account #

Address of Financial Institution

Street/P.O. City, State & Zip & Phone

Savings Checking

You MUST notify us of changes to your name, address, & contact info by completing a Vendor Activation/Change form. Locate our forms at: http://www.maine.gov/occ/forms/index.shtml (Under VENDOR section.)

NEW Bank Info: New bank info is REQUIRED to be written on this document.

Name on Account

Routing #

Name of Financial Institution

Account #

Address of Financial Institution

Street/P.O. City, State & Zip & Phone

Savings Checking

We require you to submit a voided check or letter from your bank for account verification.

Signature of Payee*

Date

(Benefit Recipient) or Authorized Agent (not a fill-in, must sign after printing)

INCOMPLETE FORMS WILL NOT BE PROCESSED

AGENCY CONTACT NAME __________________________ PHONE # ______ SHS # ______ DATE

EFT_V5   3/20/13