Private Health Insurance Premium Benefit

What is the MaineCare PHIP Benefit?

PHIP 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. Having the PHIP pay your private health insurance premium will not make you lose MaineCare.

If your child is enrolled in the Katie Beckett Program and you become eligible for the PHIP Program, your Katie Beckett premium may increase.

How does the premium get paid?

The PHIP Benefit Program will pay you (the policyholder) every month.

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. PHIP is only for people who have MaineCare and private health insurance.

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

We will need the following information to see if you are eligible for PHIP:

- Employer and Insurance Information form, enclosed with this application.
- Proof of the cost of your premium on a current pay stub or a current bill.
- The rates for the insurance to include the breakdown of cost for Employee, Employee/Spouse, Employee/Child, and Family. This should be given to you during the open enrollment period and should be attainable through your employer’s Human Resources Department.
• The annual open enrollment period dates and the effective date of the benefit period.
• The section of your benefit summary that includes your individual deductible amount.
• A copy of your medical and pharmacy insurance card, front and back.
• W-9 form, completed by the policyholder in order to reimburse you your monthly premiums.
• A completed Direct Deposit Form.
• A voided check or letter from your bank on their letterhead providing their routing number, your name, address, account number and must indicate if it is a savings or checking account. We do not accept deposit slips or a starter check.

How do I complete the PHIP application?

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 cover dental.
• **W-9 Form:** The policyholder of the health insurance should complete this form. Please fill in ONLY the policyholder’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.
• **Direct Deposit Form:** The policyholder must be on the checking or savings account. If you have a savings account that you want the check to go into, attach a letter from the bank with the account number, routing number, and name of account holder.
• **MaineCare Participants Form:** Please list the names, relationship to the policy holder; and MaineCare ID number and date of birth for each person. This form tells us who in the family is covered or will be covered by the private health insurance.

Please send the information to me by mail, email, or fax. We do not qualify you for prior months. If you have questions, please feel free to contact our office.

Sincerely,

Benefits Administrator
1-800-977-6740
Fax (207) 287-9385
**EMPLOYER AND INSURANCE INFORMATION**

<table>
<thead>
<tr>
<th>Employee Name:</th>
<th>Employee Social Security Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Address:</td>
<td>Telephone Number:</td>
</tr>
<tr>
<td>Employer Name:</td>
<td>Contact Person:</td>
</tr>
<tr>
<td>Employer Address:</td>
<td>Telephone Number:</td>
</tr>
</tbody>
</table>

Date of open enrollment: ______  
Medical Ins. Carrier Name: ________________  
Medical Ins. Carrier Address: ____________

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

<table>
<thead>
<tr>
<th>Coverage (Please X covered services)</th>
<th>How Often Deducted</th>
<th>Employee Cost</th>
<th>Single - Medical</th>
<th>Employee w/Chrm - Medical</th>
<th>Employee &amp; Spouse - Medical</th>
<th>Family - Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO, PPO</td>
<td>Weekly ↓</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
</tr>
<tr>
<td>Maj. Med/Comp. Plan</td>
<td>Please circle <strong>50 or 52</strong> times/yr.</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>Bi-Weekly ↓</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
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<tr>
<td>Prescriptions Card</td>
<td>Please circle <strong>24 or 26</strong> times/yr.</td>
<td>____________</td>
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<tr>
<td>Vision – Exam 1yrly</td>
<td>Monthly</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
</tr>
<tr>
<td>Flexible Spending Acct</td>
<td>Yearly</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
</tr>
<tr>
<td>HSA and/or HRA Acct</td>
<td>Yearly</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
<td>____________</td>
</tr>
</tbody>
</table>

Medical Deductibles:  
Single: ____________________  
Family: ____________________

Enrolled: Medical  
Y______ N______  
Certificate # ____________________  
Group # ____________________
MaineCare Member Information

Policyholder: ____________________________________________________________
MaineCare ID# or DOB: __________________________________________________
Email Address: __________________________________________________________

MaineCare Member: ______________________________________________________
MaineCare ID# or DOB: __________________________________________________
Relationship to Policyholder: _____________________________________________

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Relationship to Policyholder: _____________________________________________

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MaineCare ID# or DOB: __________________________________________________
Relationship to Policyholder: _____________________________________________
STATE OF MAINE
ACTIVATION/CHANGE REQUEST FOR DIRECT DEPOSIT / EFT

MAIL TO:

Choose ONE

We require you to submit a voided check or letter from your TIN of Payee*

agency or department you are doing business with. (i.e., DHHS/Labor/DEP)

agency. The agency is required to notify the State of Maine of any changes that may affect these instructions or the agency's ability to comply with them. This authorization may be canceled at any time by notifying the agency in writing. In authorizing the above services to be provided to me/us, I/we agree to hold the Agency and the State of Maine harmless from any and all loss, cost, damage or expenses I/we may suffer as a 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.

Payee's Name

Choose ONE

TIN is required - Employer ID No. or Social Security No.

Contact Person's Name & SSN

Phone # (If different from Payee)

EIN

Address of Payee

Vendor Code

Include VC or VS

(Stree/PO, City, State, & Zip)

One Vendor Code (VC/VS) Number per form & can be provided by agency.

Email

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:

The bank account information must be accurate and complete. I/we agree to notify the agency immediately of any changes in the account. I/we agree to notify the agency of any 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 ONLY - For new bank set up, please skip to NEW section below.

Name on Account

Routing #

(Transit/ABA #)

Name of Financial Institution

Account #

Address of Financial Institution

Choose ONE

(Street/PO, 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/osc/forms/index.shtml (Under VENDOR section.)

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

Name on Account*

Routing # *

(Transit/ABA #)

Name of Financial Institution*

Account # *

Address of Financial Institution*

(Street/PO, City, State, Zip & Phone)

Choose ONE

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

For agency use only

AGENCY CONTACT NAME

PHONE #

SRS #

DATE

EFT_V6 11/14/14