P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-6660/800-705-9173/Fax 801-442-0382
selecthealth.org/hiputah

HIPUtah
Utah Comprehensive Health Insurance Pool

Eligibility Verification Form

Please return your form in the enclosed envelope provided by HIPUtah.
Incomplete forms may jeopardize your enrollment in the HIPUtah Plan. Please make sure you complete BOTH sides.

ENROLLEE INFORMATION

Name _____
Last First Initial

Date of Birth ____/____/____ Subscriber ID# _____ Sex ❑ M ❑ F

Marital Status ❑ Single ❑ Legally Married ❑ Separated ❑ Divorced

Street Address _____
City State ZIP

Home Phone (_____) _____ Occupation _____

Does your employer pay all or part of your HIPUtah premiums? . . . . . ❑ Yes ❑ No

Guardian/Responsible Party *(to be completed when the enrollee is a minor or lacks the legal ability to complete this form)*

Name _____
Last First Initial Relationship

ENROLLEE ELIGIBILITY VERIFICATION

1. Are you a citizen of the United States of America? . . . . . ❑ Yes ❑ No
   If no, please explain citizenship status _____
2. Are you a legal resident in the state of Utah? . . . . . ❑ Yes ❑ No
   If no, please explain _____
3. Are you a resident or inmate of a public institution (hospital, care facility, prison, halfway house)? . . . . . ❑ Yes ❑ No
   If yes, give the name of the institution and date of admission or incarceration _____
4. Are you eligible for Medicare? . . . . . ❑ Yes ❑ No
   If yes, please explain why you are not enrolled in Medicare _____
   _____
5. Are you covered under COBRA? . . . . . ❑ Yes ❑ No
6. Are you eligible for state-sponsored programs other than HIPUtah (i.e. Medicaid or Children's Health Insurance Pool)? . . . . . ❑ Yes ❑ No
   If yes, please explain why you are not enrolled in this coverage _____
7. Are you eligible for medical benefits through the US Dept. of Veterans Affairs (VA)? . . ❑ Yes ❑ No
   If yes, please explain why you are not enrolled in this coverage _____
8. Are you eligible for coverage through the Federal Employee Health Benefits Plan (FEHB)? . . . . . ❑ Yes ❑ No
   If yes, please explain why you are not enrolled in this coverage _____
9. Are you eligible for any other health coverage? . . . . . ❑ Yes ❑ No
   If yes, please explain why you are not enrolled in this coverage _____

GROUP COVERAGE

Complete all that apply.

Enrollee

Employer _____

Does your employer provide group health coverage? . . . . . ❑ Yes ❑ No

If yes, are you eligible for employer coverage? . . . . . ❑ Yes ❑ No

Please explain _____

_____

Enrollee's Spouse

Name _____

Employer _____

Does your employer provide group health coverage? . . . . . ❑ Yes ❑ No

If yes, are you eligible for employer coverage? . . . . . ❑ Yes ❑ No

Please explain _____

_____

Enrollee's Guardian

Name _____

Employer _____

Does your employer provide group health coverage? . . . . . ❑ Yes ❑ No

If yes, are you eligible for employer coverage? . . . . . ❑ Yes ❑ No

Please explain _____

_____

Enrollee's Guardian's Spouse

Name _____

Employer _____

Does your employer provide group health coverage? . . . . . ❑ Yes ❑ No

If yes, are you eligible for employer coverage? . . . . . ❑ Yes ❑ No

Please explain _____

_____

I certify that the above answers are true and correct, and I agree to immediately notify the Utah Comprehensive Health Insurance Pool (HIPUtah) should any of the answers to the above questions change.

Signature_____ Date_____

Enrollee Signature (If a minor, signature should be parent or guardian.)