Washington State Health Care Authority

Application for HCA Premium Payment Program

HOH #: _____WA

Your name	Telephone number ( )	Email address (optional)

Street address	City	State	Zip code

Who in your family is covered by the private health insurance?

Name *(please enter subscribers information on line 1)*	Relationship to subscriber	Date of birth	On Medicaid?	Social Security number or ProviderOne number
1.	**SELF**		☐ yes ☐ no	
2.			☐ yes ☐ no	
3.			☐ yes ☐ no	
4.			☐ yes ☐ no	
5.			☐ yes ☐ no	
6.			☐ yes ☐ no	

Who is your health insurance provider? (this information is on your insurance card)

Name of your private health insurance company	Telephone number ( )

Company address	City	State	Zip code

Source of Insurance: ☐ Employer* ☐ COBRA ☐ Individual ☐ Other: _____

When is your open enrollment date? _____/_____/_____ Effective Date: _____/_____/_____

***If employer, please attach a copy of a recent paycheck stub, and fill in the following:**

Employers name	Telephone number ( )

Health Insurance Premium (from your billing statement or employer/paycheck)

How much do you pay for this insurance?	How often do you pay?	How do you pay this premium?
$ _____	☐ weekly ☐ monthly	☐ deducted from pay
Is it Pre-Tax? ☐ Yes ☐ No	☐ bi-weekly ☐ semi monthly	☐ deducted from pension
		☐ check
		☐ bank account withdrawal
		☐ other: _____

Please sign to indicate you would like to be considered for premium assistance

Signature	Date

For fastest service:

- Provide all information requested.
- Attach current copies of your health insurance payment or a recent paystub if your employer provides health insurance.
- Attach current copies of your insurance card (front and back).

Return to:

Washington Health Care Authority;
Premium Payment Program; PO Box 45518; Olympia, WA 98599-5518
Fax: 1-877-893-3810; Phone: 1-800-562-3022 Ext. 15473