# PREMIUM ASSISTANCE REVIEW FORM

*Please review the information below to ensure it is accurate. If the information is not correct, please write in the correct information so we may update our files. If any of the health insurance information for this individual is not populated, please report the correct information*

|  | **INFORMATION ON FILE** | **UPCOMING PLAN INFORMATION – (IF DIFFERENT)** |
| --- | --- | --- |
| **Policy Holder/Member** | [Policyholder First Last Name] | [Policyholder First Last Name] |
| **Employer Name** | [Employer Name] | [Employer Name] |
| **Employer’s Human Resource Address** | [Employer Address | [Employer Address |
| **Insurance Company** | [Insurance Company] | [Insurance Company] |
| **Type of Plan** | [ ]  HMO [ ]  PPO [ ]  POS [ ]  EPO [ ]  Major Medical [ ]  Indemnity | [ ]  HMO [ ]  PPO [ ]  POS [ ]  EPO [ ]  Major Medical [ ]  Indemnity |
| **Plan Tier** | [ ]  Individual [ ]  Dual [ ]  Couple [ ]  Family | [ ]  Individual [ ]  Dual [ ]  Couple [ ]  Family |
| **Policy Number** | [Policy ID] | [Policy ID] |
| **Group Number** | [Group ID] | [Group ID] |
| **Policy Start Date:** (MM/DD/YYYY) | [Policy Start Date] | [Policy Start Date] |
| **Total Monthly Premium**  | [Total monthly premium] | [Total monthly premium] |
| **Monthly Employer Contribution** | [Employer monthly Contribution] | [Employer monthly Contribution] |
| **Monthly Employee Contribution** | [Employee monthly Contribution] | [Employee monthly Contribution] |
| **Rate Year** (dates premium rates are effective)**:**  | [Rate Year] | [Rate Year] |
| **Individuals covered by Policy (MassHealth ID)** | [Member First and last name and Medicaid ID] | [Member First and last name and Medicaid ID] |
| **Other Notes:** |  |

Name of Human Resources/Benefits Person Completing Form

Phone Number: Date:

* All Premium Assistance Review Forms must include a copy of the Summary of Benefits (which describes the coverage, deductible, out of pocket max, etc. for the health insurance plan you are enrolled in).
[ ]  Summary of Benefits attached
* If this plan is not through your employer, please provide a copy of a bill or statement from your insurance company indicating your monthly premium cost.

[ ]  Copy of Insurance Bill or Statement is Attached (only applies to policies not provided by employer
or COBRA plans)