PEEHIP FPL & CHIP
(05/09)
2G

FEDERAL POVERTY LEVEL ASSISTANCE APPLICATION (FPL)

AND

CHILDREN'S HEALTH INSURANCE PROGRAM APPLICATION (CHIP)

I'm applying for:
☐ FPL
☐ CHIP
☐ FPL and CHIP

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
Web site: www.rsa-al.gov

This form is to be used to apply for the Federal Poverty Level Premium Assistance and/or to apply/enroll in PEEHIP CHIP.

PEEHIP Subscriber Information - *Required*

Name must be entered as shown on your Social Security card.

Social Security Number	First Name	Middle Name/Initial	Last Name
_____-_____-_____			

Mailing Address	City	State	ZIP Code

Home Phone	Work Phone	Date Received *(For internal use only)*
_____-_____-_____	_____-_____-_____	_____/_____/_____

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Children's Health Insurance Plan Applicants Only

Note: *Social Security Number is required for all household members. Name must be entered as it appears on the Social Security card.*

Is any child covered under Medicaid? ☐ Yes ☐ No If yes, which child(ren)?

Names of Household Members *Line A – PEEHIP Subscriber* *Line B – Subscriber's Spouse* *Lines C-F – Children under 19 years of age living in your home*	Social Security Number	Date of Birth	Age	Sex	Relationship to PEEHIP Subscriber
A.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	Self
B.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	Spouse
C.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	
D.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	
E.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	
F.	_____-_____-_____	_____/_____/_____		☐ M ☐ F	

Requested Effective Date _____/_____/_____ *(required)*

If you do not qualify for CHIP, do you wish to enroll children under the PEEHIP Hospital/Medical Plan? ☐ Yes ☐ No

Do any of these dependent children have other health insurance coverage? ☐ Yes ☐ No

If yes, which child(ren)? *(A copy of the insurance card is required.)*

Instructions

1. A **signed** copy of your prior year's Federal Income Tax Return Form 1040, 1040A, or 1040EZ along with copies of all supporting 1099's and W-2's must be attached. If you were married and did not file a joint return, you must also file a copy of your spouse's prior year's Federal Income Tax Return Form 1040, 1040A, or 1040EZ along with copies of all supporting 1099's and W-2's in order for this application to be processed.
2. You must reapply for this assistance every year during Open Enrollment.
3. Any Federal Poverty Level assistance application received and/or postmarked after the close of Open Enrollment (September 1) will be effective for the first day of the second month after the receipt and approval of the application.

PEEHIP Subscriber Certification - *Required*

I declare that the above information and the accompanying tax returns and supporting 1099's and W-2's are true, complete, and accurate. I understand that submitting false or misleading information on this application is a crime punishable under state and federal law. I also understand that if any statements or accompanying tax returns and supporting 1099's and W-2's are found to be incorrect, incomplete, false, or misleading, I will be required to repay all discounts plus interest. This certification authorizes the Alabama Department of Revenue (or corresponding agency of the state of member's residency) to release to PEEHIP all of the member's and his/her spouse's tax returns in the agency's records for the current and prior tax year.

Employee Signature ______________________________ Date Signed _____/_____/_____

Spouse Signature ______________________________ Date Signed _____/_____/_____

Please mail the completed form to the address located on the top of this form.
See reverse for FPL discounts and levels.

FEDERAL POVERTY LEVEL ASSISTANCE PROGRAM (FPL)

PEEHIP provides premium assistance to PEEHIP members with a combined family income of less than or equal to 200% of the Federal Poverty Level (FPL) as defined by Federal Law. To qualify for the FPL assistance, PEEHIP members must furnish acceptable proof of total income based on their most recently filed Federal Income Tax Return. Certification of Income Level will be effective for the plan year only, and re-certification will be required annually during Open Enrollment. The premium reduction does not automatically renew each year. The premium reduction will apply only to the hospital medical premium or HMO premium and only applies to active and retired members. The FPL premium discount is not available to members who are on a Leave of Absence, COBRA or surviving spouse contract.

Federal Poverty Level Premium Discount:

Over 200% of the FPL	member pays 100% of the member contribution	
equal to or less than 200% but more than 175% of the FPL	member contribution reduced 10%	Member pays 90%
equal to or less than 175% but more than 150% of the FPL	member contribution reduced 20%	Member pays 80%
equal to or less than 150% but more than 125% of the FPL	member contribution reduced 30%	Member pays 70%
equal to or less than 125% but more than 100% of the FPL	member contribution reduced 40%	Member pays 60%
equal to or less than 100% of the FPL	member contribution reduced 50%	Member pays 50%

2009 Federal Poverty Levels (FPL)

Family Size	100% of FPL	125% of FPL	175% of FPL	200% of FPL	300% of FPL
1 member	$10,830	$13,538	$18,953	$21,660	$32,490
2 members	$14,570	$18,213	$25,498	$29,140	$43,710
3 members	$18,310	$22,888	$32,043	$36,620	$54,930
4 members	$22,050	$27,563	$38,588	$44,100	$66,150
5 members	$25,790	$32,238	$45,133	$51,580	$77,370
6 members	$29,530	$36,913	$51,678	$59,060	$88,590
7 members	$33,270	$41,588	$58,223	$66,540	$99,810
8 members	$37,010	$46,263	$64,768	$74,020	$111,030
For each additional person, add	$3,740	$4,675	$6,545	$7,480	$11,220