Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Office of MaineCare Services
Private Health Insurance Premium (PHIP)
11 State House Station
Augusta, Maine 04333-0011
Toll Free: (800) 977-6740; Fax: (207) 287-9385
TTY: Dial 711 (Maine Relay)

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

Employee Name:	_____	Employee Social Security Number:	_____
Employee Address:	_____	Telephone Number:	_____
Employer Name:	_____	Contact Person:	_____
Employer Address:	_____	Telephone Number:	_____

Date of open enrollment: _____

Medical Ins. Carrier Name: _____ Medical Ins. Carrier Address: _____

PLEASE ONLY SHOW HOW MUCH IS ACTUALLY BEING DEDUCTED FROM PAYCHECK

	Employee Cost	How Often Deducted		Coverage (Please X covered services)
Single - Medical	_____	_____	Weekly ↓	_____ HMO, PPO
Employee w/Chrn - Medical	_____		Please circle **50 or 52** times/yr.	_____ Maj. Med/Comp. Plan
Employee & Spouse - Medical	_____		Bi-Weekly ↓	_____ Prescriptions
Family - Medical	_____	_____	Please circle **24 or 26** times/yr.	_____ Prescriptions Card
		_____	Monthly	_____ Vision – Exam 1yrly
		_____		_____ Flexible Spending Acct
		_____	Yearly	_____ HSA and/or HRA Acct

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: _____

MaineCare Member: _____
MaineCare ID# or DOB: _____
Relationship to Policyholder: _____

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MaineCare ID# or DOB: _____
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State of Maine Substitute W-9 & Vendor Authorization Form

RETURN TO: *by mail the agency who requested the form or sent it to you, or the agency you're doing business with. (ie.. DHHS/Labor/ DEP/Education/etc)*

PURPOSE: To establish or update an account with the State of Maine's accounting system.
Complete this form if: 1) You will receive payment from the State of Maine, and/or 2) You are a vendor who provides services or goods to the State of Maine.
This form replaces the IRS W-9 form per the IRS W-9 language; "If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9."

FILL OUT FORM COMPLETELY - ALL AREAS WITH * ARE REQUIRED - ONLY ONE NAME & TIN PER A FORM

TYPE OF REQUEST*: (Must select one.)

☐ New Request | ☐ New Location/Additional Entry | ☐ Change ○ Legal Name ○ Phone # ○ Contact Info ○ Payment Address ○ DBA Name ○ Care Of ○ Email Only ○ Ordering Address

TAXPAYER ID NUMBER* (TIN) ***(Provide ONE only)*** Social Security # (person) or a Federal Employer ID # (business) TIN

TIN Type * choose ONE	Organization Type *	Classification * choose ONE				
○ Social Security No. ⇨	○ Individual ⇨	☐ Individual	☐ Nonresident Alien	☐ Estate		
		☐ Sole Proprietorship				
○ Employer ID No. ⇨	○ Company ⇨	☐ Corporation	☐ Partnership	☐ Trust	☐ Estate	☐ Other Non-Profit Org
		☐ Other Gov't	☐ Federal Gov't	☐ State Gov't	☐ Other	☐ Foreign (W8 required)

LEGAL NAME ***(Must provide: Legal name filed with IRS tied to the ID number, SSN=first & last name/FEIN=business name)***

Legal Name* Alias/DBA

Other Info Vendor Customer Number (if known) VC#/VS# Account/Client/Provider Number (if known)

Payment Address* My ☐ **Billing Address** ☐ **Admin. Address** is the same.

Address C/O

City/State/Zip Phone

Contact*

Name Phone Ext

Email ☐ Send me Email notifications of DD/EFT (requires Direct Deposit/EFT form to be completed)

Procurement/Physical Address* My ☐ **Billing Address** ☐ **Admin. Address** is the same.

Address C/O

City/State/Zip Phone

Contact*

Name Phone Ext

Email

Authorized Signature, Title & Current Date*

Under penalties of perjury, I certify that: 1) The number shown on this form is my correct taxpayer identification number, and 2)I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3) I am a U. S. citizen or other U. S. person (defined by the IRS). Ref: www.irs.gov

OFFICE USE ONLY
State Agency & SHS #

Information on State Agency Submitting Vendor Form
Agency Contact Person Name & Title

OFFICE USE ONLY
Contact's Phone #

STATE OF MAINE
ACTIVATION/CHANGE REQUEST FOR DIRECT DEPOSIT / EFT

MAIL TO:

AGENCY RETURN LABEL/STAMP

State agency or department you are doing business with. (ie.. DHHS/Labor/DEP)

We require you to submit a voided check or letter from your bank for account verification.

Choose ONE
☐ NEW
☐ CHANGE

Payee's Name

TIN of Payee*

Choose ONE
☐ SSN
☐ EIN

**TIN is required ~ Employer ID No. or Social Security No.*

Contact Person's Name & Phone # (If different from Payee)

Vendor Code *Include VC or VS*

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

Address of Payee (Street/PO, City, State, & Zip)

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:

I, the below signed, authorize you to electronically transfer payments to the account provided below. I/we authorize the Agency to initiate credit entries and debit entries (only for the purposes of correcting an erroneous credit provided that, prior to the debit I/we are notified by the Agency in writing of the reason) to my/our account at the below named financial institution. I/we agree to notify the Agency's offices immediately upon discovery of any errors resulting from transactions under this authorization and to notify the Agency's offices of any changes that may affect these instructions or the Agency's ability to rely upon them. This authorization may be canceled by me/us 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 the 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.

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

Choose ONE
☐ 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 # SHS # DATE