Colorado HIBI Program
1550 Larimer St Box #1000
Denver, CO 80202

<<Date>>
<<FirstName>> <<LastName>>
<<Address>>
<<City>>, <<ST>> <<Zip>>

Dear <<First Name>> <<Last Name>>,

As a Colorado Health Insurance Buy-In (HIBI) program participant, you are responsible for keeping your personal information on file up-to-date. Please provide the following information.

To process your changes, the Colorado HIBI program must receive a copy of the front and back of your insurance card, the premium rate sheet, summary of benefits, and a recent paystub or other verification to show proof of your premium payment.

You can either fax a copy of this form and other documentation to (855) 226-4424 or send your documents to our mailing address: Colorado HIBI Program, 1550 Larimer St. Box #1000, Denver, CO 80202.

Thank you for keeping your information current. This will help you receive timely reimbursements. If you have any questions, you may call our toll-free number (855) MyCOHIBI or (855) 692-6442.

Colorado HIBI Information Change Form

Health Insurance Member: First/ Middle/ Last Name: _____

Mailing Address: _____ Apt#: _____ Change Date: _____

Phone #: _____ Cell #: _____ E-mail Address: _____

Insurance company: _____

Premium amount paid: _____ List how often premium is paid: _____
(Attach a premium rate sheet from your employer or insurance representative.)

List any new or reinstated health insurance member(s):_____
(If needed, use additional paper to list names.)

Bank Name: _____ Account #: _____ Routing #:_____
(Please attach a copy of your voided check.)

I authorize any person, medical provider, insurance company, or other organization to provide any information about me or my dependent's health insurance, medical treatment and employment to the Department of Health Care Policy and Financing and its business associates upon request.

Signature:_____ Date: _____