<<Date>> Case Number: <*Case no*>

<<Member Name>> PIER ID: *<PIER ID>*

<<Address>>

<<City>>, <<ST>> <<Zip>>

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

The Colorado Health Insurance Buy-In (HIBI) program is currently reevaluating your eligibility to participate in the program. **You are required to update your information every year** to ensure that we have the most recent information about your health insurance coverage and confirm that you continue to remain eligible for the Colorado HIBI program.

Please complete the information on the following page and return the signed form along with the requested documents by mail or fax to the address or fax number below.

Please indicate if your health insurance company, your policy number or your group number has changed.

**Please complete the appropriate forms and supply the requested documents as soon as possible to prevent disruption to your HIBI benefits. If we do not receive the requested documents prior to the requested plan year, it may result in a delay or loss of HIBI payment.**

|  |  |
| --- | --- |
| Fax:  | 855-226-4424 |
| Mail: | Colorado HIBI Program1550 Larimer StBox 1000Denver, Colorado 80202 |

Sincerely,

Your HIBI Team

 <<Date>> Case Number: <*Case no*>

<<Member Name>> PIER ID: *<PIER ID>*

<<Address>>

<<City>>, <<ST>> <<Zip>>

**Colorado Health Insurance Buy-In (HIBI) Renewal**

1. Health Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Has your Health Insurance Company changed? ❏Yes❏ No Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Is this a new Policy Number? ❏Yes ❏No Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Is this a new Group Number? ❏Yes ❏No Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dental Insurance Company Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Dependent Name | Date of Birth | Medicaid ID (if applicable) | Relationship to Member | Added/Dropped Members | Chronic Medical Condition(s) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

2. Are you adding or dropping any dependents from your insurance plan? ❏ Yes ❏ No
**If Yes**, please complete the following:

3. My current providers are in-network. ❏ Yes ❏ No

4. Please provide a copy of:

* 1. Your insurance card.
	2. Rate information for your upcoming plan year for all coverage levels (employee/individual only; employee/individual + spouse; employee/individual + child(ren); and family). Your human resources department or insurance broker should be able to provide this information.
	3. Summary of Benefits for your health insurance for the upcoming year (including deductible and coinsurance amounts).
1. Verification of your plan rate change must be received **within 30 days of your new policy effective date** (e.g., paystub, cleared check to the insurance carrier, bank statement showing payment).

**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:**  \_\_\_\_\_\_\_\_\_\_ \_

**Phone #:** **Email Address:**  \_\_\_

Remember to report any changes to your email, phone number, address, employment, or insurance coverage to the Colorado HIBI Customer Service Team. Failure to do so may delay payment of your premiums.
855-MyCOHIBI (855-692-6442) | CustomerService@myCOHIBI.com