Aetna Better Health® Kids
1425 Union Meeting Road
Blue Bell, PA 19422
Fax: 1-860-754-1055

CHIP Health Insurance Renewal Form

1. Household Information.

Head of Household Name:	First:	MI:	Last:	Suffix:
Address:	Street:		Apt #:	
	City:	State:	Zip:	Email:
Phone:	Primary:	Alternate:	Best time to call:	

2. Household Individuals. Please list all the people who live in your household.

Name	Are you applying for, or renewing health benefits for this person?	Date of Birth (Mo/Day/Yr)	Social Security Number	Citizenship Status	Gender	Marital Status	Is this person a student?	How is this person related to the Head of Household?
	Yes No				M F		Yes No	
	Yes No				M F		Yes No	
	Yes No				M F		Yes No	
	Yes No				M F		Yes No	
	Yes No				M F		Yes No	
	Yes No				M F		Yes No	

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3. Tax Filing Status

Do any of the persons listed on this application plan to file a federal income tax return NEXT YEAR? ___Yes ___No
If yes, list each tax filer and list the spouse of the tax filer if filing a joint return.

Complete this information for your spouse/partner and children who live with you and/or anyone else on your same federal income tax return if you file one. Include yourself, your spouse or unmarried partner, and anyone under 21 who lives with you and anyone you include on your tax return (even if they do not live with you).

Name of Tax Filer	If Filing Jointly – Name of Spouse

Will any of the persons listed on the application claim any dependents on their tax return? ___Yes ___No **If yes,** list tax filer and list dependents.

A dependent can be claimed by only one tax filer. For joint filers, you need to list dependents for the tax filer who will sign the tax form.

Name of Tax filer	Name and Date of Birth of Dependents

You do not need to complete the information in the table below if the dependent is already listed above.

Will any of the persons listed on the application be claimed as a dependent on someone else's tax return? ___Yes ___No
If yes, list dependent, and list tax filer for whom the dependent will be claimed.

Name of Dependent	Name and Date of Birth of Tax Filer	Relationship to Tax Filer

4a. Income

Income: Income includes, but is not limited to:

- Wages, salaries, tips, bonuses, commissions, etc.
- Interest
- Dividends
- Taxable refunds, credits, or offsets of state and local income taxes
- Alimony received
- Self-employment net profit/loss
- Capital/other gain/loss
- IRA distributions
- Pensions and annuities
- Rental real estate, royalties, trusts and REMIC
- Farm income/loss
- Unemployment compensation
- Worker's compensation
- Social Security benefits
- Other income

Does anyone in your household have any income? ___Yes ___No **If yes,** list any income you have already received, or expect to receive, this year:

Name	**Source of Income** (employer, unemployment, social security, etc.)	**How Often** Weekly, biweekly, monthly, once, etc.	**Amount Before Taxes**	**Date First Began** Mo/Day/Yr

Does anyone's income change from month-to-month (for example, seasonal employment)? ___Yes ___No
If yes, list the person(s) whose income changes and their total expected income this year and next year.

Name	**Total expected income and number of months worked this year**	**Total expected income and number of months worked next year**

4b. Tax Deductions

If anyone pays for certain things that can be deducted on a federal income tax return, telling us about them could lower your health insurance cost. You must send us proof of deductions. These deductions are found on line 23-35 of the 1040 form or lines 16-19 of the 1040A form.

Note: You should not include a cost that you already included in your answer to net self-employment.

Eligible tax deductions are:

- Educator expenses
- Certain business expenses of reservists, performing artists, and fee-basis government officials
- Health saving account deduction
- Job-related moving expenses
- Deductible part of self-employment tax
- Self-employed SEP, SIMPLE, and qualified plans
- Self-employed health insurance deduction
- Penalty on early withdrawal of savings
- Alimony paid
- IRA deduction
- Student loan interest deduction
- Tuition and fees
- Domestic production

Does anyone in your household have any tax deductions? ____Yes ____No

If yes, list any deductions you have already received, or expect to receive. **You must send us proof of deductions.**

Name	**Type of Deduction**	**How Much**	**How Often** Once, Monthly, Quarterly, etc.	**Date First Began** Mo/Day/Yr

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5. Health Insurance Coverage	Does anyone in the household have a current health insurance card that is not CHIP? If YES, complete this section.			
Policy Information:	Policy Holder Name:		Insurance Company Name:	
	Policy Number:	Group Number/Name:	When did the policy start?	When did/will the policy end?
Who is Covered?	Name:	Name:	Name:	Name:
What is covered?	____ Hospital Care ____ Doctor's Visits	____ Prescriptions ____ Dental	____ Vision ____ Medicare	____ Medical Assistance

6. Pregnancy Is anyone in the household pregnant? If YES, complete this section.	
Name	**Due Date**

7. Disability Does anyone in the household have a permanent disability? If YES, complete this section.	
Name	**Type of Disability**

Confirmation (Signature Required to Complete this Renewal)

You must **read and sign the last page of this form** if you are using this paper form to renew your child's CHIP benefits.
Please use the return envelope provided.

Please read and sign the last page or your renewal will not be complete!

You have certain rights and responsibilities.

CHIP

- Confidentiality – All information on this application will be kept confidential. This application will be shared only with the programs for which you apply and/or may be eligible, such as the Medical Assistance program.
- Designate a Personal Representative – You may select another person to receive health related information regarding you or your minor child(ren) by completing a Personal Representative Designation form.
- Certificate of Creditable Coverage – When you leave the program, you will receive a certificate of creditable coverage to verify medical coverage, if you are eligible.
- Written Notice – You will be given a written notice explaining your eligibility.
- Appeal – You may request an impartial review if you do not agree with any decision made regarding this application, if the request is made within 30 days of the decision.

You have a responsibility to:

- Read and fully understand this application.
- Provide true, correct and complete information, understanding that there are penalties for knowingly giving false information; it is a serious offense and considered criminal insurance fraud.
- Help with the review of this application, which may include interviews and reviewing health records.
- Be aware that certain information may be subject to verification from employers, financial sources and other third parties.
- Provide proof of identity and U.S. citizenship or legal immigration status if that information is not obtained through this application process.
- Provide proof of income and tax deductions if that information is not obtained through this application process.
- Report all changes regarding your household including income, family members, address and telephone number

Medical Assistance

- I understand that Pennsylvania receives information from other state and federal agencies to verify the information I give them. If I misrepresent, hide, or withhold facts which may affect my eligibility for benefits, I may be required to repay my benefits, and I may be prosecuted and disqualified from receiving certain future benefits.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application. I understand that the information entered in this application will be kept confidential and used only to administer benefits. I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
- I understand that any changes I am required to report must be reported within the first 10 days of the month following the month of change.
- I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended, or stopped, the written notice will explain why.
- I understand that I will have 30 days from the date of the notice to request a hearing if I do not agree with the decision made on this application.
- I understand that my situation is subject to verification from employers, financial sources, and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I must use the Electronic Benefit Transfer (EBT) or the PA ACCESS Card only during the period I am eligible. I must use the EBT or the PA ACCESS Card only for the person who is eligible and I may get only the benefits that are needed and reasonable.
- I understand that I do not have to provide a Social Security Number for anyone who is not applying for Medical Assistance. If I do provide their Social Security Number, it may be used to check the information on this application.
- I certify that all information that has been entered is true under penalty of perjury.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP. If this is the case, I authorize the Department of Public Welfare to give my name and information on this application to the Insurance Department or the CHIP contractor. I understand my rights and responsibilities under CHIP.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for federal benefits and/or explore private health care options through

as soon as they occur.	the Health Insurance Marketplace. If this is the case, I authorize the Department to give my name and information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.

I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.

If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give any and all information on this application to the Marketplace. I understand my rights and responsibilities under the Health Insurance Marketplace.

If it is determined that my child is eligible for or enrolled in state employees' health care benefits from a public agency and the agency would pay even a small portion of the benefit or premium cost, then my child is not eligible for CHIP. If this is the case and my child has been receiving CHIP benefits, my child's CHIP benefits may be retroactively terminated.

I certify that, to the best of my knowledge, I understand my rights and responsibilities and that the information included in this application is complete and true under penalty of perjury. I also certify that knowingly providing false or incomplete information on this application is insurance fraud.

I understand that all individuals applying will be provided access to coverage under the program for which they are eligible, if they are found eligible for Medical Assistance or CHIP.

I will allow the Pennsylvania Insurance Department to give any and all information found on this application to the Department of Public Welfare if any applicants may be eligible for Medical Assistance.

I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP and Medical Assistance programs.

I certify that the person(s) I am applying for are U.S. citizens or aliens in lawful immigration status. (I understand this certification does not apply to an alien who is applying only for Medical Assistance Emergency Health Care benefits.)

I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the program(s) for which I am applying.

Signature of Applicant or Person Applying for Applicant(s):

X____Date: _____________

YOU MUST SIGN AND DATE THIS APPLICATION OR IT CANNOT BE PROCESSED!