



Pennsylvania's Children's
Health Insurance Program
We Cover All Kids.



Health Insurance Renewal Form

Date of Letter: 10/20/2011
KidzPartners
901 Market Street, Suite 500
Philadelphia, PA 19107

Member ID:

Renewal Due Date:

Dear :

It's time to renew your child(ren)'s CHIP health insurance coverage! If you do not renew your child(ren)'s CHIP coverage by , their healthcare benefits will end. If you renew, NOW, your child(ren)'s doctor's visits, prescriptions, dental, eye, emergency and other healthcare services will be covered for another year.

There are three easy ways to renew CHIP coverage! To keep CHIP coverage, you can:

1. RENEW ONLINE USING COMPASS (If you apply online, most of your information will already be filled in for you, which will save you time):

- Go to www.compass.state.pa.us and click on "Renew your benefits";
- Select "A Pennsylvania Insurance Department benefit(s): Children's Health Insurance Program (CHIP) or adultBasic" and click "Continue";
- Enter your UFI, Member ID, and renewal month (listed in top right corner of this form) and click "Continue";
- Update or add any information by following the online directions;
- Click "Submit" when you are finished; and
- You will still need to mail or fax your proof of current income. Please write your **E-form number** (provided by COMPASS) on your documents.

If you need help while using COMPASS, click the "Help" link or call 1-800-986-KIDS (5437).

2. RENEW OVER THE PHONE:

- Call 1-800-986-KIDS (5437) to renew over the phone. To renew over the phone, you will need the same information as listed above.
- You will still need to sign the last page of this form and mail or fax it and copies of your proof of current income to us. Please be sure to write your **E-form** number (provided by our representative during your call) on all your documents.

3. RENEW USING THIS PAPER FORM:

This form lists the most current information you reported to us. Please review all of the information carefully and be sure to do the following:

- Make any changes and add information that is missing directly on the form. If you need more space, attach another sheet of paper;
- Sign and date the form and provide copies of your proof of income; and
- Mail or fax the entire Renewal Form with your proof of current income copies to us immediately in the envelope provided.

If you have any questions or need help with your renewal, please call us at 1-888-888-1211, Monday through Friday 8:00 am to 7:00 pm.
TTY users please call 1-877-454-8477. Fax number: 215-967-9281.

Si necesita ayuda para traducir esta informacion, por favor comuniquese con el departamento de Servicios a Miembros del KidzPartners al
1-888-888-1211. Usuarios del sistema TTY deberan llamar al 1-877-454-8477. Número de fax: 215-967-9281.



Health Insurance Renewal Form

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?	Is this person still living in the household?	Date of Birth (MM/DD/YYYY)	Social Security Number	Citizenship Status	Gender	Marital Status	Is this person a student?	How is this person related to the Head of Household?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	

3. Income Information. In the next two sections, please tell us about your household's earned and unearned income. You must send us proof of income.

Proof of earned and unearned income is:

- One pay stub from the last 60 days (send more stubs if your pay changes regularly) OR a note from your employer with your gross income and how often you get paid.
- If you are self-employed: last year's tax return with all schedules OR a list of your income and expenses.
- Unemployment check stubs and award letter
- Social Security, pension, or Worker's Compensation check, award letter or bank statement.
- Copies of support orders or checks, if you receive regular child support.

Health Insurance Renewal Form

Earned Income: Earned income includes income from a job or self-employment. You must send us proof of income (as listed above). Send copies - we cannot send originals back to you. Add an additional sheet of paper for additional earned incomes.

Income # 1:				
Whose income is this?	Name:	Income Source:		Do you still have this income? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer/Business Name:		How much income? \$ (Amount before taxes)		How often is this amount received?(weekly, every two weeks, monthly, or yearly)
Income # 2:				
Whose income is this?	Name:	Income Source:		Do you still have this income? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer/Business Name:		How much income? \$ (Amount before taxes)		How often is this amount received?(weekly, every two weeks, monthly, or yearly)
Income # 3:				
Whose income is this?	Name:	Income Source:		Do you still have this income? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer/Business Name:		How much income? \$ (Amount before taxes)		How often is this amount received?(weekly, every two weeks, monthly, or yearly)
Income # 4:				
Whose income is this?	Name:	Income Source:		Do you still have this income? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer/Business Name:		How much income? \$ (Amount before taxes)		How often is this amount received?(weekly, every two weeks, monthly, or yearly)

Unearned Income. Unearned income sources include income from retirement/pension plans, worker's compensation, social security, child support payments, and unemployment benefits. You must send us proof of income (as listed above). Send copies - we cannot send originals back to you. Add an additional sheet of paper for additional unearned incomes.

Whose income is this?	Income Source	Do you still have this income?	How much income? (Amount before taxes)	How often is this amount received? (weekly, every two weeks, monthly, or yearly)
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Health Insurance Renewal Form

4. Dependent Care Expenses Does anyone in the household pay for child OR adult daycare for another member of the household? If YES, complete this section for each person in care.				
Who is in care?	How much do you pay each month?	How many months each year?	Who in the home pays for this care?	Do you still have this expense?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Health Insurance Coverage Does anyone in the household have a current health insurance card that is <u>not</u> CHIP that they use for health care? If YES, complete this section.				
Policy Information:	Name on Policy:		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?	<input type="checkbox"/> Hospital Care <input type="checkbox"/> Prescriptions <input type="checkbox"/> Vision <input type="checkbox"/> Medical Assistance <input type="checkbox"/> Doctor's Visits <input type="checkbox"/> Dental <input type="checkbox"/> Medicare			

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