~ YOUR FAMILY'S HEALTH IS IMPORTANT TO US! ~
It's time to reenroll in Hoosier Healthwise

Dear Hoosier Healthwise Member:

Please take a few minutes to fill out this form and return it to us in the attached postage paid envelope. We will use the information you give us to review your eligibility for Hoosier Healthwise. Please return this form to us no later than _____ so that we can process your reenrollment without delay.

If you don't have the papers that we ask for, or if you have any questions, please call me,

_____ at _____.
(Name of caseworker)

(If you need more room to answer the questions, please use the back of the form.)

1. Please give your address and telephone number, including another telephone number if there is one.

_____ Home phone:_____

_____ Other phone:_____

2. List your family members in living your household.

_____

_____

3. If employed, list your employer(s) and address(es).

_____

4. If your pay is the same amount every payday, please attach your most current paystub, or a copy. If your pay is different each payday, please attach paystubs, or copies, for the last month.

5. If you are self-employed, attach a copy of last year's income tax return, or other proof of income.

6. List other income such as unemployment, child support, Social Security, sick pay, strike pay etc. Please attach papers that show the amount of this income.

_____

7. If you have other health insurance, please list the name of the company and ID number.

_____

8. If you pay child care cost, list the monthly amount: _____

I certify under penalty of perjury that the information provided on this form is correct and complete to the best of my knowledge and belief.

_____ _____
(signature) (Date signed)

If you want to change your primary care doctor, call the Hoosier Healthwise Helpline at (800) 889-9949.

Thank you very much for your cooperation!

Case Number:

_____

Case Name:

_____