FAMIS *Select* – Application

WHAT IS FAMIS *Select*?

FAMIS *Select* is a voluntary program that gives families with children **approved for FAMIS** greater flexibility and choice in providing for their family's heath care coverage. FAMIS *Select* can help families pay for part of their health insurance premiums at work or for a private insurance plan.

INSTRUCTIONS: The policyholder or person who carries the insurance plan should complete this application. Please print all information and check application for completeness. FAMIS *Select* enrollment will begin the month after approval of your FAMIS *Select* Application. Read the back of this application for detailed instructions. **Proof of Insurance payment must be included with the application in order to process.** When you have answered all the questions, sign and return to**: FAMIS *Select* Unit, DMAS, Suite 1300, 600 East Broad Street, Richmond, VA. 23219. Phone: (804) 786-7024 (Richmond Area), 1- 888-802-5437 (Rest of State) or Fax to (804) 225-3961 Attn: FAMIS Select.**

SECTION 1 - Personal Information of Applicant (Policyholder)

Name:		**Social Security Number:** (Not Required)	
Address (Street, PO Box, etc.):			
City:	**State:**	**Zip Code:**	**Home Phone # ( )** **Work Phone # ( )**

SECTION 2 – Information on Health Insurance Policy

Name and Address of Insurance Company:	**Employer's Plan** ☐ **Private Insurance Plan** ☐ **Effective Date: / /** **Policy #:**

Check the Benefits Covered by the Plan:

☐ Doctor visits	☐ Well-child check-ups	☐ Dental care
☐ Hospital & emergency care	☐ Immunizations	☐ Vision Care
☐ Lab & X-rays	☐ Prescription drugs	☐ Mental Health Care

☐ Other (Please explain if this policy has special or limited benefits such as for accidents only or cancer only)

Note: The employee must apply for the full premium contribution from the employer.

SECTION 3 - List **ALL** Family Members Covered by Plan and Check if Approved by FAMIS

NAME	DATE OF BIRTH	RELATIONSHIP	FAMIS-APPROVED
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

SECTION 4 – Insurance Premium Information (Amount paid by policyholder does not include employer's contribution)

Amount paid for Health Insurance **Per paycheck $**	Amount paid for Dental Insurance **Per paycheck $**	Amount paid for Vision Insurance **Per paycheck $**	Number of Pay Periods per month insurance is deducted from **4☐ 2☐ 1☐ other ☐**

For Private Health Plans Amount paid for Health Insurance **Per month $**	Amount paid for Dental Insurance **Per month $**	Amount paid for Vision Insurance **Per month $**

Disclaimer: The FAMIS *Select* program will not provide premium assistance payments to a non-custodial parent who is under a court order to provide medical support.

Signature of Policyholder:	**Date:**
Signature of Custodial Parent: **(if different than policyholder)**	**Date:**

FAMIS *Select* -Application Instructions

How do I apply?
To get started, simply fill-out the application. **If you have additional questions, contact the FAMIS *Select* Unit at (804) 786-7024 or toll-free at 1-888-802-5437.**

Section 1 Personal Information of Applicant (Policyholder): The policyholder is the person who carries the insurance plan. Complete this section by listing your name, social security number (not required) address, city/county of residence and phone numbers (work and home).

Section 2 Information on Health Insurance Policy: Complete this section by indicating the name and address of your health insurance company/plan, check if your plan is an employer's plan or a private plan and include the effective date and policy number. In the next box, check the benefits that are covered by your plan.

Note: The applicant completing this form and receiving health insurance from an employer must apply for the full contribution available from the employer.

Section 3 List ALL Family Members Covered by Plan and Check if Approved by FAMIS: Provide information on all family members, including adults, that will be covered by the applicant's employer-sponsored health plan or by a private health plan. For each person, write the name, date of birth, your relationship to the person, and if the person is a child, check if they are approved for FAMIS.

Section 4 Insurance Premium for Health and Dental: ***Write in "amount paid" by policyholder per paycheck for health, vision, and dental. In the next box, check the box that indicates the number of pay periods for insurance deductions each month.*** **4 is weekly, 2 is bi-weekly, 1 is monthly) Please state if other.**

Proof of Insurance payment must be included with the application in order to process.

Signature: If you are the policyholder, sign on the first line. If the policyholder is not a custodial parent, then a custodial parent must also sign the second line.

Final checklist:
- ☐ did you answer all the questions?
- ☐ did you attach your pay-stub or proof of an insurance payment?
- ☐ did you sign the application?

Mail to FAMIS *Select*
600 East Broad Street, Suite 1300
Richmond, VA 23219, or Fax to (804) 225-3961.

Each month send to FAMIS *Select* a pay-stub that shows insurance is being deducted or proof you have paid for private health insurance. It is very important that you report any changes in your health care coverage to FAMIS *Select* IMMEDIATELY. Failure to do so may result in repayments to the Virginia Department of Medical Assistance Service

HELP US KEEP YOUR CHILDREN COVERED – TELL US IF YOU CHANGE JOBS, DROP THE INSURANCE PLAN, HAVE A NEW ADDRESS (CHECKS CANNOT BE FORWARDED), OR PURCHASE A NEW PLAN.