New Jersey Department of Health
Health Insurance Continuation Program
PO Box 363
Trenton, NJ 08625-0363

INSTRUCTIONS FOR COMPLETING THE *RENEWAL* APPLICATION FOR PARTICIPATION IN THE HEALTH INSURANCE CONTINUATION PROGRAM (HICP)

Before you begin completing the renewal application form, please take a few minutes to review these specific instructions. While many of the questions are self-explanatory, some require additional clarification to be completed correctly.

If you need assistance completing this renewal application, call toll free 1-800-353-3232.

SECTION I – PERSONAL INFORMATION

Question 2 - Providing your Social Security Number is mandatory and will speed up the processing of your renewal application.

Question 3 - Enter your principal place of residence. The residency requirement states that you must be a resident of New Jersey for at least 30 days prior to the date of this renewal application.

If your residence address has changed, please provide two (2) proofs of residency which are current and dated. The date must be clearly visible and no more than six (6) months old. Sample proofs of residency include but are not limited to:

- Motor Vehicle Records (e.g. Valid Driver's License
- Social Security Form #2458 or Third Party Query Form
- Landlord's records and rent receipts
- Public utility records and receipts (electric, gas, phone bill)
- Personal property assessment records
- Bills of business or professional people (doctors, department stores)
- Post Office records
- Records of social agencies, public or private
- Employment records

SECTION II – HOUSEHOLD INCOME

Question 9 - Enter household income as requested. Also attach verification of income (i.e., pay stubs, unemployment stubs).
If you are married or a member of a civil union, enter your income **PLUS** your spouse's/partner's income.
If you are claimed as a dependent for income tax purposes, then provide proof of income for the claimant.

Fill in ALL of the blanks. List gross figures unless otherwise indicated. If your income for any category is zero, write "0" in that space.

Maximum allowable household income limits for this Program are:

Number of Persons in Household*	Maximum Allowable Household Income
1	$58.350
2	$78,650
3	$98,950
4	$119,250
5	$139,550

*For households with more than 5 persons, add $20,300 for each additional person.

BEFORE YOU MAIL YOUR *RENEWAL* APPLICATION:

REVIEW THIS CHECKLIST AND MAKE SURE THAT EACH OF THE FOLLOWING ITEMS IS MAILED WITH YOUR APPLICATION:

- ☐ *RENEWAL* APPLICATION FOR PARTICIPATION IN THE HEALTH INSURANCE CONTINUATION PROGRAM (DHAS-34) (Completed and signed)
- ☐ TWO (2) PROOFS OF RESIDENCY, IF ADDRESS HAS CHANGED
- ☐ VERIFICATION OF INCOME (pay stubs), IF CHANGED
- ☐ W-2, INCOME TAX 1040, IF CHANGED

MAIL ABOVE ITEMS (COMPLETED RENEWAL APPLICATION) TO THE ADDRESS ABOVE.

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Health Insurance Continuation Program
PO Box 363
Trenton, NJ 08625-0363

FOR STATE USE ONLY
Record #

RENEWAL
APPLICATION FOR PARTICIPATION IN THE HEALTH INSURANCE CONTINUATION PROGRAM

Please print clearly and answer all questions. If you need assistance completing the renewal application, call toll free 1-800-353-3232. Mail the completed renewal application to the Health Insurance Continuation Program, at the address given above. Send copies of any requested documents. Do not send originals as they WILL NOT be returned.

1. DO YOU CURRENTLY HAVE HEALTH INSURANCE COVERAGE? ☐ **YES** ☐ **NO**

IF "YES," PLEASE COMPLETE THIS RENEWAL APPLICATION.

IF "NO," DO NOT CONTINUE SINCE YOU ARE NOT ELIGIBLE FOR PARTICIPATION IN THE HEALTH INSURANCE CONTINUATION PROGRAM.

2. DO YOU CURRENTLY HAVE MEDICATION COVERAGE BY THE AIDS DRUG DISTRIBUTION PROGRAM (ADDP)? ☐ **YES** ☐ **NO**

SECTION I – PERSONAL INFORMATION

1. Applicant Name (Last, First, MI)	2. Social Security Number _____ - _____ - _____
3. Street Address	4. Date of Birth _____ / _____ / _____
5. City, State, Zip Code	6. County

7. Telephone Numbers
Home: ( ) _____ Cell: ( ) _____

NOTE: IF YOUR RESIDENCE ADDRESS HAS CHANGED, PLEASE PROVIDE TWO (2) PROOFS OF RESIDENCY WITH YOUR APPLICATION.

8.. Case Manager
Name: _____ Phone Number: ( ) _____

SECTION II - HOUSEHOLD INCOME

In Column A, enter your ACTUAL HOUSEHOLD income, from all sources, for last year. In Column B, enter what you EXPECT your HOUSEHOLD income will be, from all sources, for the current calendar year. If your income from any of the sources listed below was "0" last year or is expected to be "0" this year, enter "0" in that column. Enter ONLY whole dollar amounts ($), do not list cents (c). DO NOT LEAVE ANY BLANKS!

9. Sources of Income ***Attach additional sheet, if necessary.***	**COLUMN A 20 _____ Last Year Annual Income**		**COLUMN B 20 _____ Current Year Annual Income**		**FOR STATE USE ONLY**	
	(1) Applicant and Spouse/Partner	**(2) Others**	**(1) Applicant and Spouse/Partner**	**(2) Others**	**A / S/P**	**O**
Salary (Before Payroll Deductions)						
Unemployment Benefits						
Social Security Benefits (Net)						
Medicare Part B Annual Premium						
Pension Benefits (Identify in Section IV)						
Interest and Dividends						
Net Rental Income (After Expenses)						
Additional Income (Specify):						
TOTAL ANNUAL INCOME (FOR EACH COLUMN)						

RENEWAL APPLICATION FOR PARTICIPATION IN THE HEALTH INSURANCE CONTINUATION PROGRAM (Continued)

1. Applicant Name (Last, First, MI)	2. Social Security Number _____ - _____ - _____

10. Have you applied for or are you currently receiving the following? (Check ALL that apply)

Applied For	Receiving		Applied For	Receiving	
☐	☐	AFDC	☐	☐	Social Security Disability Insurance (see Instructions)
☐	☐	Food Stamps			
☐	☐	Housing Assistance	☐	☐	Unemployment Compensation
☐	☐	Welfare	☐	☐	Worker's Compensation
☐	☐	Social Security Insurance			

SECTION III - CERTIFICATION AND AUTHORIZATION BY APPLICANT

a. I certify that the information given is true and accurate to the best of my knowledge.

b. I will notify the Program immediately if my/our income rises above the legal limits (as stated in the instructions); if I move from New Jersey; if I become Medicaid/Welfare/PAAD eligible; or if there is any change in premium payments or type of policy.

c. I authorize release of information necessary to determine my eligibility for the Health Insurance Continuation Program from the records in possession of the Social Security Administration, Internal Revenue Service and the New Jersey Division of Taxation, employers, banks and others as the need arises. I authorize my physician to release information for the purpose of determining my eligibility to participate in the Health Insurance Continuation Program.

d. I understand that I may be visited by a representative of the New Jersey Department of Health, Health Insurance Continuation Program, in order to verify my/our eligibility.

e. I understand that the Health Insurance Continuation Program is entitled to repayment for incorrectly provided benefits. I further understand that I will be held liable for any premium payments that are determined to have been incorrectly provided on my behalf.

f. I understand that the Health Insurance Continuation Program reserves the right to limit enrollment based upon the availability of funds.

11. Signature of Applicant	12. Date of Application
13. Signature of Spouse/Partner, if Married/Civil Union	14. Date