Employer Payroll Deduction Authorization

The person submitting this form wishes to have deductions made from their payroll distribution and sent to Managed Health Services (MHS) for Healthy Indiana Plan (HIP) health insurance premium payments. The employee should complete the "Employee Information" below, and a copy of the completed form should be faxed or mailed to MHS at the address on the bottom of this form. Payroll deductions associated with this employee's request should also be mailed to the address below. Please contact MHS Member Services at 1-877-647-4848 with questions.

Employee Information

Name: _____

Member ID (MID)/ HIP ID #: _____

Address:_____

Name of Employer: _____

Begin date (Must be the first of the month): _____

Amount to Be Withheld Each Pay Period: $ _____

Please list how you are paid:

☐ Weekly ☐ Every two weeks ☐ Every month

☐Other (please list): _____

Authorization

I hereby authorize _____ to make deductions from any compensation or monies due to me in the amount listed above. The monies deducted will be applied to contributions required to be made to MHS, Incorporated for participation in HIP. The deductions will be taken through the current calendar year, or until I no longer wish to participate or until I terminate my employment.

Employee Signature: _____ Date:_____

By signing this form, I attest that I have read and understand the above authorization.

Employer Information

Payroll Address: _____

City: _____ State: _____ ZIP: _____

Contact Name: _____ Contact Phone: _____

Employer agrees to this optional program to allow employee deductions and forwarding to MHS? ☐Yes ☐No

Please fax or mail this form to: MHS, Attn: HIP Billing, PO Box 441548, Indianapolis IN, 46244. FAX: 1-866-855-9947.

The employer and employee should retain a copy of this form.