State of California
Health and Human Services Agency

Department of Health Care Services

Health Insurance Premium Payment (HIPP) Program

APPOINTMENT OF REPRESENTATIVE

(or additional contact) – (optional)

Name (Last, First, Middle)	**Relationship/Organization**	☐ Additional contact only ☐ Authorized to act on my behalf ☐ Both
Address		
Daytime Telephone Number	**Email Address**	

Name (Last, First, Middle)	**Relationship/Organization**	☐ Additional contact only ☐ Authorized to act on my behalf ☐ Both
Address		
Daytime Telephone Number	**Email Address**	

Signature of Applicant or Guardian _____ **Date** _____

IMPORTANT: As a condition of eligibility, all Medi-Cal beneficiaries shall assign rights to medical insurance, support, or other third-party payments to the Medi-Cal program and shall cooperate with the California Department of Health Care Services (DHCS) in obtaining medical support or payments. The assignment of rights to benefits is effective only for services paid for by the Medi-Cal program. This Assignment allows DHCS to recover funds from health insurance companies when the Medi-Cal program pays for medical services which should have been billed to other health coverage. Please note that in order to comply with the Federal Privacy Act (42 USC, Section 552a), your Social Security Number and any information you provide may be disclosed to insurance companies, employers, health care service providers and county agencies to determine the extent of available health insurance. Under Welfare and Institutions Code, Section 14100.2, any submitted information is considered confidential and disclosed only as necessary for Medi-Cal program administration purposes.

Declaration: I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application and the documents provided are true and correct to the best of my knowledge.

Name of Applicant *(print):*	**Signature of Applicant/Guardian:**	**Date:**
Name of Policyholder *(print):*	**Signature of Policyholder:**	**Date:**