Texas Health and Human Services Commission

Medical Insurance Input

Form H1039
July 1997

Case Name			Case No.
Category	Type Prog.	BJN	Mail Code

ELIGIBLE CLIENT(S)

CLIENT NO.	CLIENT NAME	CURRENTLY HAS COVERAGE			COVERAGE IS AVAILABLE BUT NOT ENROLLED		POLICY HOLDER IS CLIENT'S:				
		Policy No. (1 or 2)	Begin Date	End Date	Policy No. (1 or 2)	Begin Date	Spouse	Parent	Non-Custodial Parent	Self	Other
							S	P	N	SL	O
							S	P	N	SL	O
							S	P	N	SL	O
							S	P	N	SL	O
							S	P	N	SL	O
							S	P	N	SL	O
							S	P	N	SL	O

POLICY NO. 1

1. Insurance Company Name	2. Insurance Co. Telephone No.	3. Ins. No.
4. Insurance Company Address (Street, City, State, ZIP)		
5. Policy Holder/Employee	6. Policy Holder SSN	7. Policy Holder's Phone No.
8. Policy No.		9. Group No.
10. Is premium deducted (or could it be deducted) from policyholder's wages/pension? ☐ **Yes** ☐ **No**	If yes, monthly amount: **$**	11. Does policy holder need help obtaining/keeping coverage for self/family members? ☐ **Yes** ☐ **No**
12. Employer/Union Name		13. Employer/Union Telephone No.
14. Employer/Union Address (Street, City, State, ZIP)		

POLICY NO. 2

1. Insurance Company Name	2. Insurance Co. Telephone No.	3. Ins. No.
4. Insurance Company Address (Street, City, State, ZIP)		
5. Policy Holder/Employee	6. Policy Holder SSN	7. Policy Holder's Phone No.
8. Policy No.		9. Group No.
10. Is premium deducted (or could it be deducted) from policyholder's wages/pension? ☐ **Yes** ☐ **No**	If yes, monthly amount: **$**	11. Does policy holder need help obtaining/keeping coverage for self/family members? ☐ **Yes** ☐ **No**
12. Employer/Union Name		13. Employer/Union Telephone No.
14. Employer/Union Address (Street, City, State, ZIP)		

Worker Name (please print)	Telephone No. (inc. A/C)

Signature–Worker

Date