Department of Health Services
Division of Public Health
F-001423 (01/2025)

State of Wisconsin
Phone: 1-800-991-5532
Fax: 608-266-1288

HIV Drug Assistance and Insurance Assistance Program
Insurance Enrollment Report

Contact Information

Last Name	First Name	Date of Birth

Case Manager Name	Case Management Agency

Section 1: Insurance Information (check at least one box)

I have signed up for (a):

- ☐ BadgerCare
- ☐ COBRA Plan
- ☐ Dental Plan
- ☐ Insurance through work
- ☐ Silver Plan through the Marketplace (ACA)
- ☐ Medicare Part C Plan with drug coverage
- ☐ Medicare Part D Plan
- ☐ Medicare Supplement Plan
- ☐ Medicaid Purchase Plan (MAPP)
- ☐ None of the options

Section 2: Insurance Policy Information

(Please be complete. You may need to contact your insurance company for this information.)

Important: Attach any documents regarding your insurance. This may be a payment book, invoice, or marketplace printout showing premium and tax credit amounts. Use both policy sections if you have more than one plan type

Insurance Policy Information

Insurance Company and Plan Type

Payment Mailing Address	City, State, ZIP Code

Policy Start Date	Policy End Date	Policy Number

Payment Amount	**Due Date (do not use ASAP)**	**Payment is Made** ☐ Monthly ☐ Quarterly ☐ Annually

Insurance Company and Plan Type

Payment Mailing Address	City, State, ZIP Code

Policy Start Date	Policy End Date	Policy Number

Payment Amount	**Due Date (do not use ASAP)**	**Payment is Made** ☐ Monthly ☐ Quarterly ☐ Annually

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