



Permission to Share MRMIP Information

Applicant's Name: _____
Please print first and last name

HCID or Subscriber Number: _____

I give permission for the Major Risk Medical Insurance Program (MRMIP) to give information over the telephone about the status of my MRMIP application, enrollment or premium payments to the person listed below. This permission will end on the date the program mails the results of its review, regarding the information checked below.

Person's Name: _____
Please print first and last name

Agent/Broker CA License Number (if applicable): _____

Please check **one** of the boxes to let us know what type of information we may share:

- Initial application process
- Initial enrollment or effective date of coverage
- Disenrollment process
- Premium payment research
- Appeals process

Applicant's Signature: ➡ _____ **Date:** _____

Mail this form to:

Major Risk Medical Insurance Program
Attention: MRMIP Enrollment Unit
P.O. Box 9044
Oxnard, CA 93031-9044

Or, fax it to: **1-805-987-6084**

Questions? Call 1-800-289-6574, Monday - Friday, 8:30 a.m. to 7:00 p.m.. The call is free.