Application

Non-Medicare Plans

Questions? Call 1-800-877-5187

Please type or PRINT in black ink. All sections must be filled out completely. **Your premium and required documents should be included with your signed application.** Timely and complete submission of all documents will expedite the enrollment process. (You may Fax your application if the original and premium payment are sent by mail within 5 days.) **You must be a resident of Washington state and meet other eligibility criteria to apply**. If you are eligible for Medicare, do not fill out this application; request our Medicare-Eligible Basic Plan application.

SECTION 1: AGENT INFORMATION

If you are applying through an Agent, the Agent must provide the information below and sign this section.

Agent Name		Firm or Agency	
Agent Mailing Address	City	State	Zip Code
Agent Phone ( )		Agent Email Address	
Agent's Washington State License Number		❒ Copy of current license attached* ❒ Copy of current license on file with WSHIP* * **Must be attached or on file to receive agent commission**	
Agent's Tax I.D. Number		❒ Pay commission to firm ❒ Pay commission to agent	❒ W-9 form attached ❒ W-9 form on file with WSHIP

Agent Statement: I certify I have verified that all persons applying for coverage are eligible. I further certify, to the best of my knowledge, the information on this application and the Standard Health Questionnaire (if applicable) has been completed truthfully by the Applicant(s).

Agent Signature: X ________________________________ **Date Signed:** ____________________

SECTION 2: APPLICANT INFORMATION

Last Name	First Name	MI	Social Security Number - -
❒ Male ❒ Female	Birth Date (MM / DD / YYYY) / /	Age	
Street Address (***required; must attach proof)***	City	State	Zip Code
County of Residence	Home Phone ( )	Work Phone or Cell Phone ( )	
Email Address	Secondary Contact Person Name*	Secondary Contact Person Phone ( )	
Name of Custodial Parent / Guardian if Applicant is a Minor or Not Legally Competent			
(If different from above) Billing Address and Name of Organization Responsible for Payment **(if applicable)**			
Billing Address	City	State	Zip Code
Organization Paying Premiums	Organization Contact Person	Organization Contact Person Phone ( )	
Receiving DSHS Medical Assistance? ❒ Yes ❒ No	***If yes, attach your DSHS or Healthy Options ID card.***		

* Secondary contact is a person who will know how to get in touch with you if we are unable to reach you. This person is not a personal representative unless a Personal Representative Form has been submitted for him/her.

FOR OFFICE USE ONLY Effective Date:____/____/________

SECTION 3: PLAN SELECTION

Check one box to indicate your plan selection and deductible option:

1. **Preferred Provider Plan** — Deductible: (4 options) ❒ $500 ❒ $1,000 ❒ $2,500 ❒ $5,000
2. **HSA Qualified Preferred Provider Plan** (combined medical & pharmacy deductible) — Deductible: ❒ $3,000
3. **Limited Preferred Provider Plan "A"** — Deductible: ❒ $1,500
4. **Limited Preferred Provider Plan "B"** — Deductible: ❒ $1,500
5. **Standard Plan** — Deductible: (3 options) ❒ $500 ❒ $1,000 ❒ $1,500

NOTE: Once enrolled, you may only switch plans effective January 1st each year and you may only change to a plan that has the same or higher deductible and is not more comprehensive than your current plan.

SECTION 4: DEPENDENT INFORMATION *(if more than two, list on separate sheet or copy page)*

If you are eligible for WSHIP and enroll, you can elect to cover your dependent children. They do not have to be rejected by a health carrier. Dependent children must be unmarried, and under age 19 (unless disabled).

Additional premiums are required for each dependent.

List dependents to be covered below: (only list dependents you want covered by WSHIP)

A

Dependent Last Name	First Name	MI	Social Security Number
			- -

Relationship to Applicant	Birth Date (MM / DD / YYYY)	Age
	/ /	

Disabled and 19 and older? ❒ Yes ❒ No

If yes, receiving Social Security disability? ❒ Yes ❒ No
Entitlement date: / /

Receiving DSHS Medical Assistance? ❒ Yes ❒ No ***If yes, attach your DSHS or Healthy Options ID card.***

B

Dependent Last Name	First Name	MI	Social Security Number
			- -

Relationship to Applicant	Birth Date (MM / DD / YYYY)	Age
	/ /	

Disabled and 19 and older? ❒ Yes ❒ No

If yes, receiving Social Security disability? ❒ Yes ❒ No
Entitlement date: / /

Receiving DSHS Medical Assistance? ❒ Yes ❒ No ***If yes, attach your DSHS or Healthy Options ID card.***

Is Applicant or any Dependent listed above currently insured through WSHIP? ❒ Yes ❒ No

If yes, name of person(s):

Relationship to Applicant: ______________________________ Policy Number: _________________________

SECTION 5: OTHER COVERAGE

WSHIP will pay secondary to any other coverage unless preempted by federal law.

Do you or any person named on this application have any other medical or hospital insurance including public programs such as Medicare or Medicaid? ❒ Yes ❒ No

If yes, complete the following for each person(s) and attach copy of identification card(s):
(if more than one coverage, list on separate sheet or copy page)

Last Name	First Name	MI	Social Security Number - -
Insurer Name	Insurer Phone ( )		Policy Number
Description of Coverage	Effective Date: / /		Termination Date: / /
Is it a Group Plan? ❒ Yes ❒ No	Is it your intent to replace it with this coverage? ❒ Yes ❒ No ***(If yes, remember to cancel your other coverage.)***		

SECTION 6: ELIGIBILITY INFORMATION

I certify that I am eligible for coverage because I meet the following THREE requirements:

1 **I AM A RESIDENT OF THE STATE OF WASHINGTON**

"Resident" means a person who is domiciled in Washington state for purposes other than obtaining insurance. Domicile denotes a person's permanent home and place of habitation. Evidence of residency includes, but is not limited to, one of the documents listed below. WSHIP may request additional proof of residency.

I have included a copy of one of the following documents as proof of residency (proof must match your home street address in Section 2):

Check one box to indicate the document you are including. Do not send original; it will not be returned.

- ❒ A bill in your name from any public utility at your dwelling in Washington state (excludes cell phone bills)
- ❒ Receipts for rent, mortgage or lease payments for your dwelling in Washington state
- ❒ A Washington state driver's license or state identification card
- ❒ Proof of registration and payment in Washington of taxes and fees on motor vehicles
- ❒ Proof of employment in Washington state
- ❒ A voter registration card
- ❒ A federal tax return as a resident of Washington state
- ❒ Bank statement (excludes credit card statements)

2 **I MEET ONE OF THE ELIGIBILITY CATEGORIES LISTED BELOW:**

Check one box below for the eligibility category you are applying under:

❒ **I WAS REJECTED FOR OTHER HEALTH COVERAGE FOR MEDICAL REASONS**
I received notification of rejection for coverage from a Washington state licensed health carrier based on the results of the Standard Health Questionnaire (SHQ). WSHIP will accept a denial notice for up to 90 days from the date of the denial. Applicants may be required to reapply to a health carrier if the denial was received more than 90 days from the WSHIP application date.

I have included a copy of the health carriers' rejection notice and SHQ scoring page. ***Please do not include the entire SHQ, only the scoring page (last page of questionnaire).***

❒ **I RESIDE IN A COUNTY WITHOUT INDIVIDUAL COVERAGE**
I reside in one of the state of Washington counties where individual health benefit plans are not marketed to the general public by a health carrier. **Name of county:**_____________________________.

3 **I AM NOT ELIGIBLE FOR MEDICARE**

YOU ARE NOT ELIGIBLE FOR WSHIP COVERAGE IF ANY OF THE FOLLOWING APPLY:

- You have terminated coverage in WSHIP within the last 12 months, unless you can show that you had continuous other coverage from the date WSHIP coverage terminated, which has been involuntarily terminated for any reason other than non-payment of premiums.
- WSHIP has paid out two million dollars in benefits on your behalf.
- You are an inmate of a public institution.
- You have coverage under a public program that duplicates WSHIP benefits.
- You do not reside in Washington state (except qualified resident dependent children temporarily living outside of Washington state).
- You have become eligible for medical assistance after June 30, 2008.

SECTION 7: PRE-EXISTING CONDITIONS PROVISION

WSHIP plans have a **six-month waiting period** for pre-existing conditions following the policy effective date. In certain circumstances, we will waive or credit this waiting period based on current or prior coverage.

To help us determine if you qualify for a waiver or credit towards the pre-existing condition waiting period, ***complete the following*** ***and attach a copy of your Certificate of Coverage from your current or prior health carrier***.

If you do not have a Certificate of Coverage, you may provide other documentation (such as a letter from the employer, group administrator or prior health carrier), to demonstrate prior coverage beginning and ending dates.

(if more than one coverage, list on separate sheet or copy page)

Name of Health Carrier		Telephone Number of Health Carrier ( )
Name of Subscriber (contract holder)		ID Number of Subscriber
Names of all Persons on Prior Coverage		
Date Coverage Began		Date Coverage Ended
Deductible Amount $	Out-of-Pocket Maximum Per Year $	***(If available, please attach a copy of the Summary of Benefits for this coverage.)***

Type of coverage: ☐ Individual ☐ Group ☐ Medicare ☐ Medicaid ☐ COBRA ☐ Other _______________

Type of benefits (check all that apply): ☐ Medical ☐ Hospital Only ☐ Accident Only

REDUCTION OR WAIVER OF PRE-EXISTING WAITING PERIOD

The pre-existing condition waiting period will be waived or credited to the extent you have been covered under a previous medical plan in the following circumstances:

a) Applicants will receive a pre-existing condition wait credit for time spent in their immediate previous group or non-catastrophic individual plan, if application is made to WSHIP or a health plan carrier within 63 days of termination of that previous plan. (A catastrophic plan means a plan that has a yearly $1,820 or more deductible and $3,640 or more out-of-pocket expense limit; or provides benefits for hospital inpatient/outpatient services and excludes or substantially limits outpatient physician services and those services usually provided in an office setting.)

b) WSHIP will waive the pre-existing condition wait for any person living in a county without individual coverage who is eligible for such waiver under the standards of the Federal Health Insurance Portability Act (18 months “creditable coverage” and application to WSHIP or a member health plan carrier was made within 63 days of termination).

SECTION 8: TOBACCO USE INFORMATION

The smoker rate will apply if you have used tobacco products within the past 12 months prior to this application. ***Check the applicable box below. Not checking a box will result in paying the higher rate.***

- I have used tobacco products during the prior 12 months. ❐ Yes ❐ No

NOTE: Tobacco products include cigarettes, cigars, chewing or pipe tobacco or any other tobacco products regardless of the frequency or method of use. If your tobacco use status changes, you must notify WSHIP immediately and complete a Tobacco Use Affidavit form. There will be no retroactive adjustments to rates based on tobacco use status.

SECTION 9: PAYMENT INFORMATION

Choose one of the premium payment options below:

❐ **MONTHLY BANK DRAFT** — 1 month premium due with application
You must also fill out the Bank Service Plan Authorization Form included in this application and attach a VOIDED check if you select this option.

❐ **QUARTERLY** — 3 months premiums due with application

❐ **SEMI-ANNUAL** — 6 months premiums due with application

❐ **YEARLY** — 12 months premiums due with application

To determine your premium amount:

1. Use the enclosed **Monthly Premium Rate Chart** to determine your premium payment. Select the premium indicated for the plan and deductible option you are selecting, based on your age and tobacco use status. If you need assistance, contact Customer Service at 1-800-877-5187.

   Please indicate which premium Table you used: Table #_____ Plan _______________ Deductible $_________

2. If you are applying for a low income discount (for Standard Plan only), you must first submit the undiscounted premium with your application. If you are approved, we will notify you and will credit your account. Full premium is required to be paid until a low income discount is approved.

3. **MAKE CHECKS PAYABLE TO WSHIP**. Submit your premium in the amount applicable to the billing frequency you have selected above. The premiums in our rate chart are monthly; if you choose to pay quarterly, semi-annually or yearly, please multiply the monthly premium by three, six or twelve, respectively.

NOTE: Any changes to your method of payment or automatic withdrawal, including bank information or termination of monthly bank draft**, must be submitted in writing by the 20th of the month** in order for the change to be implemented the first of the following month.

LOW INCOME DISCOUNT INFORMATION

NOTE: This discount is currently available on the Standard Plan only because premiums for our Preferred Provider Plans are already as low as the law allows (and are lower than the Standard Plan Low Income Rates).

Applicants may qualify to receive a low income discount (for Standard Plan only) if the following applies:

- Gross family income is less than 301% of the Federal Poverty Level (FPL) Guidelines (see income tables at http://aspe.hhs.gov/poverty/index.shtml or call Customer Service at 1-800-877-5187 for more information); and
- Washington state has funds available to support discounts; and
- Discount does not result in a premium that is less than 110% of the Standard Risk Rate in Washington state for the same benefits.

❐ ***Check box if you think you qualify and would like to receive a Low Income Discount Application for the Standard Plan.*** (WSHIP will send you this application and notify you of the determination; eligibility is determined by the Washington State Health Care Authority, not WSHIP.)

SECTION 10: EFFECTIVE DATE OF COVERAGE

NOTE: The **"Application Received by WSHIP Date"** is the postmark date of the application that you mailed to WSHIP or the date WSHIP receives a faxed copy of your application, whichever occurs first. The original application must be postmarked and mailed to WSHIP no later than five (5) days following the date you faxed the application to WSHIP. Once the application is approved, your insurance coverage and premiums will begin on the first (1st) of the month based on your choice.

Check one choice below to select your effective date of coverage:

❒ **AS SOON AS WSHIP CAN PROCESS MY APPLICATION**

I understand that if my application is faxed or postmarked on or before the last day of the month, then I may be eligible for WSHIP coverage effective the 1st of the next month. However, if my application is faxed or postmarked after the last day of the month, my coverage will not start until the 1st of the FOLLOWING month.

Example: If received July 31, will be effective August 1; if received August 1, will be effective September 1.

❒ **A FUTURE DATE**

This must be on the 1st of the month and can be no more than 60 days later than when your application was faxed or postmarked. (Example: If postmarked May 2, your coverage can be effective no later than July 1.)

What Future Date of Coverage do you want? (month)__________________ (year) ________

❒ **AN EARLIER DATE**

To be eligible for earlier (retroactive) effective date, these two things must be true:

a) You applied for individual coverage with a Washington State health carrier no later than the 20th of the month for an effective date of the 1st of the following month, and you were rejected; and,

b) You are mailing or faxing this WSHIP application within 15 days of receiving that carriers' Notice of Rejection.

Example: You applied to a health carrier on April 20; you were rejected and received that rejection notice on May 3; you applied to WSHIP on May 15. You may request a WSHIP effective date of May 1.

If both of the above are TRUE, you may select an effective date that your coverage with the individual carrier would have been effective:

Date of the application to the other carrier ________________________

Requested WSHIP Effective Date: (month) ________________________ (year) ________________

SECTION 11: VOLUNTARY INFORMATION

Completing this section is **voluntary** and will not affect your ability to enroll, but may help us improve our services.

Where did you hear about WSHIP?
- ❒ Health carrier (insurance company) sent me materials
- ❒ Medical office/hospital/clinic provided WSHIP brochure
- ❒ State agency
- ❒ Other: ________________________________

Where did you get your WSHIP application?
- ❒ Health carrier mailed it to me
- ❒ WSHIP website
- ❒ Called WSHIP Customer Service
- ❒ Other: ________________________________

Are you currently?
- ❒ unemployed
- ❒ employed
- ❒ self-employed
- ❒ retired

What is your yearly household income?
- ❒ Less than $18,000
- ❒ $18,000 - $36,000
- ❒ Over $36,000

# of people in household _____

Is English your first language? ❒ Yes ❒ No
If no, what is?

Do you have Internet access? ❒ Yes ❒ No

What is your occupation?

SECTION 12: DISCLOSURE CERTIFICATION AND SIGNATURE

THIS SECTION MUST BE SIGNED BY ALL ADULT APPLICANTS

By signing this form, I certify the following:

a) I have received and read an enrollment information packet containing plan summaries and understand that a complete list of benefits, exclusions and limitations is detailed in the plan Policy. I understand that I have the right to examine and return the Policy within 10 days of its delivery to me and my enclosed premium will be refunded.

b) I have filled out this application completely and my answers are true and complete, to the best of my knowledge.

c) I understand that I must be a resident of Washington state and meet other criteria to apply for and maintain coverage; I will be required to fill out and return WSHIP's Eligibility Verification Form yearly or upon request.

d) I understand that once I have selected my plan and deductible, I cannot change to a lower deductible or a more comprehensive non-Medicare plan at a later date.

e) I understand that this plan has a six-month waiting period for pre-existing conditions; this waiting period may be waived or credited based on prior health care coverage, subject to approval by WSHIP.

f) I have received WSHIP's Privacy Notice.

g) I will immediately report changes to my address or phone number, or if I become eligible for Medicare or other health insurance coverage, or if my tobacco use status changes.

h) If I wish to designate a personal representative, I have included the signed Personal Representative Form.

i) I understand that anyone who submits false information may lose coverage, may be held financially responsible for services obtained under WSHIP coverage, coverage may be terminated or rescinded as of the effective date, and I may face other penalties for prosecution and collection. WSHIP may refund premiums previously paid and recover claims and administrative costs from me or other persons responsible for intentionally falsifying information.

j) I understand that coverage will not be effective until this application has been signed, submitted in full with all requested documentation and approved by WSHIP, and the 1st month's premium payment has been submitted. Deposit of premium payment does not guarantee coverage. I understand that my application may be pended for additional information, but my Policy will be made effective as of the date for which I qualify. My check for payment will not be cashed until my application has been approved and will be returned if I am not eligible for coverage.

SIGNATURE OF APPLICANTS (or Custodial Parent if Applicant is under age 18 or not legally competent)

X / /	X / /
Signature of Applicant **Date Signed**	**Signature of Dependent (18 or older)** **Date Signed**
Print Name	Print Name

Use the CHECKLIST below to confirm you include the following:

- ❑ Signed Application – All sections filled out completely.
- ❑ Copy of proof of residency document showing your name and current address (as entered in Section 2).
- ❑ Copy of rejection notice from health carrier (within 90 days) and Standard Health Questionnaire scoring page.
- ❑ Copy of Certificate of Coverage (or other documentation) from current or prior health carrier if you are applying for a pre-existing conditions waiver or if you currently have other coverage.
- ❑ Copy of DSHS or Health Options ID card if you are receiving medical assistance.
- ❑ Check payable to WSHIP for premium payment for Applicant and each dependent you are enrolling (and retroactive premiums, if applicable).
- ❑ Completed Bank Service Plan Authorization Form with voided check if you elected monthly bank draft.
- ❑ Completed Personal Representation Form if you wish to designate a personal representative.

MAIL your application, copies of all requested documentation and applicable premium to:

Washington State Health Insurance Pool, ATTN: Enrollment
PO Box 1090, Great Bend, KS 67530

(Application may be FAXED to (620) 793-1199; original must be sent by mail within 5 business days.)

Questions? Call 1-800-877-5187 or go to www.wship.org

WASHINGTON STATE HEALTH INSURANCE POOL

BANK SERVICE PLAN AUTHORIZATION FORM

TO: The financial institution named on the Request for Bank Service Plan – Authorization Form

So that you may comply with your depositor's request, the Washington State Health Insurance Pool (WSHIP) agrees:

a) To indemnify you and hold you harmless for any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, order or direction to debit an account purporting to be executed by WSHIP and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.

b) In the event that any such check, draft, order or direction shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in forfeiture of insurance.

c) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your action taken pursuant to the foregoing request or in any manner arising by reason of your participating in the foregoing plan of premium collection.

Washington State Health Insurance Pool • PO Box 1090 • Great Bend, KS 67530

REQUEST FOR BANK SERVICE PLAN – AUTHORIZATION FORM (Optional)

For Monthly Premium Payments Only

TO: Washington State Health Insurance Pool

Please use your Bank Service Plan to make my premium payments by withdrawing funds by automatic debit entry from the account below.

WSHIP will withdraw from your account the first Friday of each month except when it falls on the 1st, 2nd, or 3rd. In that case, we will then withdraw on the second Friday of the month. If you have any questions, call WSHIP Customer Service at 1-800-877-5187.

____
Name as shown on Account   Insured / Applicant

____
Insured / Applicant Identification Number (if you are a NEW Applicant, leave blank)

____
Name of Financial Institution   Branch

____
City   State   ZIP

Transit/ABA No. ____________________________ Account No. ____________________________

Please indicate below the type of account to be debited:

Checking ❒   Savings ❒

As a convenience to me, I authorize WSHIP to pay and charge to my account automatic debit entries made upon my account by, and payable to, the order of Washington State Health Insurance Pool. I agree that WSHIP's rights with respect to each such charge will be the same as if it were personally executed by me. **This authorization is to remain in effect until WSHIP receives written notice from me to revoke it.** Any changes to your method of payment or automatic withdrawal, including bank information or termination of monthly bank draft**, must be submitted in writing by the 20th of the month** in order for the change to be implemented the first of the following month.

X____ __/__/______________
Authorized signature as shown on account   Date

ATTACH A VOIDED CHECK HERE:

Please return the Bank Service Plan to:

Washington State Health Insurance Pool
PO Box 1090
Great Bend, KS 67530

PERSONAL REPRESENTATIVE FORM (Optional)

Include this form with your application if you wish to designate someone as your Personal Representative(s) for discussion and disclosure of Personal Health Information and Personal Financial Information with WSHIP or its health plan administrator(s). This designation will not affect benefits, claims processing and payment, or eligibility status.

Type of Information

WSHIP and its health plan administrator(s) may discuss or release Personal Health Information (PHI) and Personal Financial Information (PFI) to my Personal Representative(s) regarding the following information: eligibility, billing, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals, and complaints about my health insurance coverage through the Washington State Health Insurance Pool (WSHIP), and or its health plan administrator(s).

Authorized Use and/or Disclosure

I authorize WSHIP and or its health plan administrator(s) to release PHI and PFI to the person(s) named as my Personal Representative for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Personal Representative is not a health care provider, or other person subject to federal privacy laws, my PHI and PFI may no longer be protected by those privacy laws and may be subject to re-disclosure by my Personal Representative. WSHIP and or its health plan administrator(s) are not responsible should my Personal Representative further disclose my protected PHI and PFI information. I further understand that I have the right to limit the information that you release under this authorization. Limitations for disclosure are identified below. By leaving this section blank, I am creating no limitation on disclosure of PHI of PFI.

Disclosure Limitations: ____

Expiration and Revocation

The authorization to release information to my Personal Representative(s) will automatically expire 365 days following the termination of my health plan enrollment. I understand that I may revoke this authorization at any time by giving written notice to the Plan administrator. Revocation will not affect any action that WSHIP or its health plan administrator(s) has taken, or any information that has already been released based upon prior authorizations.

Designation of Personal Representative(s)

Name of Authorized Person	Phone Number ( )	*Privacy Password
Name of Authorized Person	Phone Number ( )	*Privacy Password

**Privacy Password – such as mother's maiden name, your elementary school, birth city, etc.*

Signature and Authorization

I, the undersigned, do hereby swear that I am the above-mentioned member or an authorized legal representative of the above-mentioned member. I have read and understand the content of this Personal Representative Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

X____ ___/___/________

Signature of Member/Legal Representative Date

____

Printed Name of Legal Representative Description of Legal Representative's Relationship to Member