



WASHINGTON STATE HEALTH INSURANCE POOL

PO Box 1090
Great Bend, KS 67530
1-800-877-5187
Fax # 620-793-1199

Tray
Enrollee Name
Address 1,
Address 2
City, State zip
Bar code

IMPORTANT
This form must be SIGNED and RETURNED by
DUE DATE: DECEMBER 15, 2020

WSHIP ELIGIBILITY VERIFICATION FORM (Medicare-Eligible Plans) WSHIP must confirm that you continue to meet eligibility requirements. Your prompt response is appreciated. Failure to respond may lead to termination of your coverage. If you have questions, please call WSHIP at 1-800-877-5187.

WASHINGTON STATE RESIDENCY

1. Please provide your physical address and information below.

Table with 3 columns: Physical Address of your current residence - Required, Mailing Address if different than physical address, Billing Address of 3rd party paying premiums (if applicable). Includes fields for Name, Address, City, State & Zip, Telephone Number, Cell Number, Email Address, and Secondary Contact information.

OTHER COVERAGE INFORMATION

2. Please indicate your Medicare coverage below:

Medicare: Part A [] Part B [] Part D [] Not Eligible for Medicare* []

* If you are 65 or older but not eligible for Medicare, please enclose proof of ineligibility.

3. Are you currently enrolled in a Medicare Prescription Drug Plan (PDP)? Yes [] No []

If yes, please enclose a copy of your PDP card and indicate name and effective date below:

Name of Medicare PDP _____ Effective Date _____

4. Are you enrolled in any other coverage such as Medicaid or a group health plan? Yes [] No []

Name of other insurer _____ Effective Date _____

If you have other coverage and will CANCEL YOUR WSHIP POLICY, what is the effective date for cancellation?

PLEASE SIGN BELOW: I attest that my responses on this form are true and complete.

X
Signature
Printed Name: _____

_____/_____/_____
Date Signed
Enrollee ID # <<participant>>

SIGNATURE REQUIRED - Stamped addressed envelope enclosed