



WASHINGTON STATE HEALTH  
INSURANCE POOL

# Application

Medicare-Eligible  
Medical Supplement Plan

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 not eligible for Medicare, do not fill out this application; request our Non-Medicare Plans application.

SECTION 1: AGENT INFORMATION		<i>If you are applying through an Agent, the Agent must provide the information below and sign this section.</i>	
Agent Name		Firm or Agency	
Agent Mailing Address		City	State Zip Code
Agent Phone ( )		Agent Email Address	
Agent's Washington State License Number		<input type="checkbox"/> Copy of current license attached* <input type="checkbox"/> Copy of current license on file with WSHIP* * Must be attached or on file to receive agent commission	
Agent's Tax I.D. Number		<input type="checkbox"/> Pay commission to firm <input type="checkbox"/> W-9 form attached <input type="checkbox"/> Pay commission to agent <input type="checkbox"/> W-9 form on file with WSHIP	
<b>Agent Statement:</b> 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 has been completed truthfully by the Applicant(s).			
Agent Signature: <b>X</b> _____		Date Signed: _____	

SECTION 2: APPLICANT INFORMATION				
Last Name		First Name	MI	Social Security Number - -
<input type="checkbox"/> Male <input type="checkbox"/> Female		Birth Date (MM / DD / YYYY) / /	Age	
Street Address ( <b>required; must attach proof</b> )		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				
<b>Mailing Address (if different from above)</b>				
Address		City	State	Zip Code
<b>(If different from above) Billing Address and Name of Organization Responsible for Payment (if applicable)</b>				
Billing Address		City	State	Zip Code
Organization Paying Premium		Organization Contact Person		Organization Contact Person Phone ( )
Receiving DSHS Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, attach your DSHS or Healthy Options ID card</b>				

\* Secondary contact is a person who will know how to get in touch with you if we are unable to reach you. We are not authorized to discuss your protected health information with a secondary contact unless appropriate documentation has been submitted.

**SECTION 3: 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 under age 26 (unless disabled). Dependents must be enrolled in Medicare Part A and Part B to be eligible for the Medical Supplement Plan. Do not use this form for dependents that are not eligible for Medicare; contact WSHIP for a form to enroll non-Medicare dependent children in WSHIP.

**Additional premiums are required for each dependent.**

**List dependents to be covered below: (only list dependents you want covered by WSHIP's Medical Supplement Plan)**

<b>A</b>	Dependent Last Name	First Name	MI	Social Security Number - -
Relationship to Applicant		Birth Date (MM / DD / YYYY) / /		Age
Disabled and 26 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, receiving Social Security Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Entitlement date: / /		
Receiving DSHS Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, <u>attach</u> your DSHS or Washington Apple Health (Medicaid) ID card.</b>				

<b>B</b>	Dependent Last Name	First Name	MI	Social Security Number - -
Relationship to Applicant		Birth Date (MM / DD / YYYY) / /		Age
Disabled and 26 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, receiving Social Security Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Entitlement date: / /		
Receiving DSHS Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, <u>attach</u> your DSHS or Washington Apple Health (Medicaid) ID card.</b>				

Is Applicant or any Dependent listed above currently insured through WSHIP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If yes, name of person(s):</b>	
Relationship to Applicant: _____	Policy Number: _____

**SECTION 4: 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 in addition to Medicare Parts A and B including public programs such as 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is it your intent to replace it with this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>(If yes, remember to cancel your other coverage.)</b>		

## SECTION 5: ELIGIBILITY INFORMATION

I certify that I am eligible for coverage because I meet the following **FOUR** 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 AM ENROLLED IN MEDICARE PART A AND PART B**

I have included **a copy** of my Medicare card. (Also, for dependents to be covered who are Medicare-eligible.)

### 3 **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 MEDICARE SUPPLEMENTAL INSURANCE FOR MEDICAL REASONS**  
I received notification of rejection for coverage from a Washington State licensed Medicare supplemental policy issuer. I have included **a copy** of the issuer's rejection notice.
- I WAS OFFERED SUBSTANTIALLY REDUCED MEDICARE SUPPLEMENTAL COVERAGE**  
I have evidence of (1) a requirement of restrictive riders; (2) an up-rated premium; or (3) a pre-existing conditions limitation. I have included **a copy** of the issuer's offer notice.
- COMPREHENSIVE MEDICARE SUPPLEMENT COVERAGE IS NOT AVAILABLE IN MY COUNTY**
- COMPREHENSIVE MEDICARE SUPPLEMENT COVERAGE IS NOT AVAILABLE TO ME BECAUSE I AM UNDER AGE 65**

**Note:** Additional information may be requested. Also, WSHIP will accept an issuer letter as evidence of WSHIP eligibility for up to 180 days from the date of the letter. Applicants may be required to reapply to the issuer of Medicare supplemental coverage if the letter was received more than 180 days from the WSHIP application date.

### 4 **MY ACCESS TO A REASONABLE CHOICE OF MEDICARE ADVANTAGE PLANS (PART C)**

Medicare Advantage Plans (Part C) combine Part A and B coverage, but are provided by private insurance companies. Part D coverage may also be included. Check **one** box below for the eligibility category you are applying under:

- I reside in a county where **I do not have reasonable choice of Medicare Advantage Plans. This is defined by law as not having a choice** of health maintenance organization or preferred provider organization Medicare Advantage Plans offered by at least three different carriers that have had provider networks in the county for at least five years. Plan options must include coverage at least as comprehensive as a Plan F Medicare supplement plan combined with Medicare Parts A & B.  
**Name of county:** \_\_\_\_\_ (See WSHIP website or call Customer Service for list of counties with reasonable choice of Medicare Advantage Plans.)
- I reside in a county **with reasonable choice of Medicare Advantage Plans** but the health care provider with whom I have an established care relationship and from whom I have received care within the past 12 months is not included in any of these plans.  
**Name of provider:** \_\_\_\_\_ **Date of last care:** \_\_\_\_/\_\_\_\_/\_\_\_\_

## SECTION 6: 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. The pre-existing condition waiting period does not apply to prenatal services or benefits for outpatient prescription drugs.

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 \$	<b><i>(If available, please <u>attach</u> a copy of the Summary of Benefits for this coverage.)</i></b>
Type of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> COBRA <input type="checkbox"/> Other _____		
Type of benefits (check all that apply): <input type="checkbox"/> Medical <input type="checkbox"/> Hospital Only <input type="checkbox"/> Accident Only		

## SECTION 7: PAYMENT INFORMATION

Choose one of the premium payment options below:

- MONTHLY BANK DRAFT**      1 month premium due with application
- QUARTERLY**                      3 months premiums due with application
- SEMI-ANNUAL**                      6 months premiums due with application
- YEARLY**                              12 months premiums 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.

To determine your premium amount:

1. Use the enclosed **Monthly Premium Rate Chart** to determine your premium payment. If you need assistance, contact Customer Service at 1-800-877-5187.

*Please indicate which premium Table you used:* Table # \_\_\_\_\_

2. **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 20<sup>th</sup> of the month** in order for the change to be implemented the first of the following month.

## SECTION 8: 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 (1<sup>st</sup>) 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 1<sup>st</sup> 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 1<sup>st</sup> 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 1<sup>st</sup> 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 an earlier (retroactive) effective date, these two things must be true:

- You applied for supplemental coverage with a Washington State health carrier no later than the end of the month for an effective date of the 1<sup>st</sup> of the following month, and you were rejected; and,
- 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 30; 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 9: 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)  
 Medical office/hospital/clinic  
 State agency  
 Other: \_\_\_\_\_

**Where did you get your WSHIP application?**

- 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?



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**WASHINGTON STATE HEALTH INSURANCE POOL**

**BANK SERVICE PLAN  
AUTHORIZATION FORM**

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**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

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





WASHINGTON STATE HEALTH  
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**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 1<sup>st</sup>, 2<sup>nd</sup>, or 3<sup>rd</sup>. 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 20<sup>th</sup> 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