WSHIP
WASHINGTON STATE HEALTH INSURANCE POOL

# Application

## Medicare-Eligible Basic 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

***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<br>( ) | Agent Email Address | | |
| Agent's Washington State License Number | ❒ Copy of current license attached*<br>❒ Copy of current license on file with WSHIP*<br>* **Must be attached or on file to receive agent commission** | | |
| Agent's Tax I.D. Number | ❒ Pay commission to firm<br>❒ Pay commission to agent | ❒ W-9 form attached<br>❒ 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 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<br>- - |
| ❒ Male ❒ Female | Birth Date (MM / DD / YYYY)<br>/ / | Age | |
| Street Address (***required; must attach proof)*** | City | State | Zip Code |
| County of Residence | Home Phone<br>( ) | Work Phone or Cell Phone<br>( ) | |
| Email Address | Secondary Contact Person Name* | Secondary Contact Person Phone<br>( ) | |
| Name of Custodial Parent / Guardian if Applicant is a Minor or Not Legally Competent | | | |
| **Mailing Address (If different from above)**<br>Address City State Zip Code | | | |
| **(If different from above)** Billing Address and Name of Organization Responsible for Payment **(if applicable)** | | | |
| Billing Address | City | State | Zip Code |
| Organization Paying Premium | Organization Contact Person | Organization Contact Person Phone<br>( ) | |
| 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. 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 unmarried, and under age 26 (unless disabled). Dependents must be enrolled in Medicare Part A and Part B to be eligible for the Basic 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 Basic Plan)***

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

| **B** | Dependent Last Name | First Name | MI | Social Security Number - - |
|---|---|---|---|---|
| Relationship to Applicant | | Birth Date (MM / DD / YYYY) / / | | Age |
| Disabled and 26 and older? ❒ Yes ❒ No | | If yes, receiving Social Security Disability? ❒ Yes ❒ No<br>Entitlement date: / / | | |
| Receiving DSHS Medical Assistance? ❒ Yes ❒ No ***If yes, attach your DSHS or Washington Apple Health (Medicaid) 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 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? ❒ Yes ❒ No | Is it your intent to replace it with this coverage? ❒ Yes ❒ No<br>***(If yes, remember to cancel your other coverage.)*** | | |

## 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:** ____/____/_____
- ❒ **End State Renal Disease (ESRD)**: I have a current diagnosis of end stage renal disease and I am unable to obtain coverage by a Medicare Advantage Plan. I have included with this application a letter from my physician confirming this diagnosis including the diagnosis date.

## 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<br>(  ) |
| Name of Subscriber (contract holder) | | ID Number of Subscriber |
| Names of all Persons on Prior Coverage | | |
| Date Coverage Began | | Date Coverage Ended |
| Deductible Amount<br>$ | Out-of-Pocket Maximum Per Year<br>$ | ***(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

## SECTION 7: 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. If you need assistance, contact Customer Service at 1-800-877-5187.

   ***Please indicate which premium Table you used***: Table #_____

2. If you are applying for a low income discount, 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.

## 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 (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 an 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 end 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 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?***<br>❒ Health carrier (insurance company) sent me materials<br>❒ Medical office/hospital/clinic provided WSHIP brochure<br>❒ State agency<br>❒ Other: _____ | ***Where did you get your WSHIP application?***<br>❒ Health carrier mailed it to me<br>❒ WSHIP website<br>❒ Called WSHIP Customer Service<br>❒ Other: _____ |
| ***Are you currently?***<br>❒ unemployed<br>❒ employed<br>❒ self-employed<br>❒ retired | ***What is your yearly household income?***<br>❒ Less than $18,000<br>❒ $18,000 - $36,000<br>❒ Over $36,000<br>***# of people in household*** _____ |
| Is English your first language? ❒ Yes ❒ No<br>***If no, what is?*** | Do you have Internet access? ❒ Yes ❒ No |
| What is your occupation? | |

## SECTION 10: 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 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.

e) I have received WSHIP's Privacy Notice.

f) I will immediately report changes to my address or phone number, or if I become eligible for other health insurance coverage, or if I become ineligible for Medicare.

g) 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.

h) 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 your Medicare identification card (and cards for Medicare-eligible dependents you are enrolling)
- ❑ Copy of rejection notice or notice of reduced coverage from Medicare supplemental issuer (within 180 days)
- ❑ 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 Washington Apple Health (Medicaid) 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 Authorization for Release of Protected Health Information Form if you wish to authorize the release of protected health information to a specific individual or organization not otherwise described in our Privacy Notice.

**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**

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**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.

WSHIP
WASHINGTON STATE HEALTH INSURANCE POOL

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

WSHIP
WASHINGTON STATE HEALTH INSURANCE POOL

## 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