WSHIP
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, 2017**

**WSHIP ELIGIBILITY VERIFICATION FORM (Basic and Basic Plus 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***.

| **Physical Address of your current residence - Required** | | Mailing Address **if different** than physical address | | Billing Address **of 3rd party paying premiums (if applicable)** | |
|---|---|---|---|---|---|
| Name | | Name | | Name | |
| Address | | Address | | Address | |
| City | | City | | City | |
| State & Zip | | State & Zip | | State & Zip | |
| **COUNTY OF RESIDENCE:** | | | | | |
| **Telephone Number:** ( ) | | **Email Address:** | | | |
| **Cell Number:** ( ) | | | | | |
| *(Optional)* **Secondary Contact:** | | **Contact's Telephone Number:** ( ) | | | |
| 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. | | | | | |

**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** **Date Signed**
**Printed Name**: _____ **Enrollee ID #** **<<participant>>**

**SIGNATURE REQUIRED - *Stamped addressed envelope enclosed***