



WASHINGTON STATE HEALTH INSURANCE POOL

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

Enrollee Name
Address
City, State zip

IMPORTANT
This form must be SIGNED and RETURNED by
DUE DATE: DECEMBER 15, 2017

WSHIP ELIGIBILITY VERIFICATION FORM (Non-Medicare 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: 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). Rows include Name, Address, City, State & Zip.

COUNTY OF RESIDENCE: Important! The premium you pay is based in part on the county you live in.

Telephone Number: ()
Cell Number: ()
Email Address:

(Optional) Secondary Contact: Contact's Telephone Number:
Secondary contact is a person who will know how to contact if we are unable to do so. We are not authorized to discuss your protected health information with a secondary contact unless you submit appropriate documentation.

ARE YOU ELIGIBLE FOR MEDICARE? Yes No
If you do not know or are unsure please call: 1-800-633-4227; or visit www.cms.gov/Medicare/Medicare.html; or go to your local Social Security office.
If you have End Stage Renal Disease OR you are 65 or older but not eligible for Medicare, enclose proof of ineligibility.

ARE YOU ELIGIBLE FOR MEDICAID? (Washington Apple Health)? Yes No
Note: This includes expanded Medicaid that was implemented in 2014 as part of the Affordable Care Act.
If you don't know or are unsure please call: 1-800-562-3022 or visit www.hca.wa.gov.

DO YOU HAVE COVERAGE OTHER THAN WSHIP? Yes No
If Yes, in order to coordinate benefits, please provide the following: 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 #

SIGNATURE REQUIRED