WSHIP
WASHINGTON STATE HEALTH INSURANCE POOL

PO Box 780548
San Antonio, TX 78278
1-888-277-9135

IMPORTANT
This form must be SIGNED and RETURNED by
DUE DATE: DECEMBER 15, 2025

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 1-888-277-9135.

WASHINGTON STATE RESIDENCY: ***Please provide your physical address and information below***.

Physical Address of your current residence - Required		**Mailing Address if different than physical address**		**Name & 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:
Important! The premium you pay is based in part on the county you live in.

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

(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.

ARE YOU ELIGIBLE FOR MEDICAID? ***(Washington Apple Health)***? Yes ❑ No ❑

If you don't know or are unsure, please call: 1-800-562-3022 or visit www.hca.wa.gov. ***DSHS has more than one Medicaid option, a copy of your card is required to determine eligibility for WSHIP coverage.***

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 **Date Signed**

Printed Name: _____ **Enrollee ID #** _____

SIGNATURE REQUIRED