WSHIP
WASHINGTON STATE
HEALTH INSURANCE POOL

PO Box 21548
Eagan, MN 55121
Questions? Call 1-888-277-9135

November 2026

ACTION REQUIRED BY DECEMBER 15, 2026

IMPORTANT NOTICE ABOUT YOUR 2027 PREMIUM RATES & COVERAGE OPTIONS

(Medicare Plans)

Dear Enrollee,

This letter contains important information about your premium rate change effective January 1, 2027, and an Eligibility Verification Form that must be returned by December 15, 2026, to renew your WSHIP coverage.

COVERAGE OPTIONS

You have the option to renew your current WSHIP plan, change to WSHIP's lower-cost Medical Supplement plan if you are currently enrolled in WSHIP's Basic or Basic Plus plan, or enroll in a Medicare Advantage plan.

If you are turning age 65 soon, you may also be able to enroll in a Medicare Supplement (Medigap) plan offered by an insurance company.

Premiums for Medicare Advantage Plans and Medicare Supplement (Medigap) plans are generally much lower than WSHIP. For more information, please contact an insurance agent, call 1-800-MEDICARE or visit www.medicare.gov or call the Insurance Commissioner's SHIBA Helpline at 1-800-562-6900.

2027 WSHIP PREMIUM RATES

Your WSHIP monthly premium rate will change effective January 1, 2027. All rates have been calculated in accordance with Washington State law (RCW 48.41.200). Please consult the enclosed premium rate chart.

PREMIUM INVOICES

Premiums must be paid on or before the due date or during a 31-day grace period that follows. If your premium is not received before the end of the grace period, your coverage ends at the end of the period for which your premium was paid.

ACH PAYMENT OPTION

Monthly premiums may be paid via ACH payment (an electronic money transfer). This means your premium payment is automatically debited from your bank account each month. To use this option, please return the enclosed Bank Service Plan Authorization Form.

TO RENEW YOUR WSHIP PLAN – ACTION REQUIRED BY DECEMBER 15, 2026

To renew your WSHIP plan, please return the enclosed Eligibility Verification Form by December 15. WSHIP is required to verify continued eligibility of all enrollees. A return envelope is enclosed.

TO CHANGE OR CANCEL YOUR WSHIP COVERAGE
If you want to change to WSHIP's Medical Supplement plan or cancel your WSHIP coverage, please contact Customer Service at **1-888-277-9135** for assistance. If you do not request a plan change or cancel your WSHIP coverage, your current plan will be renewed pending receipt of your Eligibility Verification Form.

WSHIP's Lower Cost Medical Supplement Plan. If you are currently enrolled in WSHIP's Basic or Basic Plus plan, you also have the option of switching to WSHIP's Medical Supplement plan. You may find that this plan, in conjunction with a Medicare Part D plan, meets your coverage needs at a lower cost. To learn more about this plan, please contact Customer Service at 1-888-277-9135.

Medicare Advantage Plans. Medicare Advantage plans may now be available in your county. Premiums for Medicare Advantage plans may be less than WSHIP's premiums. You cannot be denied coverage because of your health status or End-Stage Renal Disease (ESRD). Some Medicare Advantage plans include prescription drug coverage, while with others you must enroll separately in a Medicare Prescription Drug Plan (PDP). For information, please contact an insurance agent, call 1-800-MEDICARE, or visit www.medicare.gov, or call the Insurance Commissioner's SHIBA Helpline at 1-800-562-6900. **The enrollment period for Medicare Advantage plans is November 15 through December 7.**

IMPORTANT REMINDER FOR ENROLLEES UNDER AGE 65
Medicare enrollees under age 65 (e.g., enrollees with kidney disease or a disability) generally have additional options for Medicare Supplement coverage when they turn age 65, and premiums may be much lower than WSHIP's premiums. To make the most of this opportunity, begin exploring your options several months before your 65th birthday. You cannot be turned down or charged a higher premium because you have a pre-existing condition as long as you enroll during Medicare's guaranteed issue period. For help comparing plans, please contact an insurance agent, call 1-800-MEDICARE, or visit www.medicare.gov, or call the Insurance Commissioner's SHIBA Helpline at 1-800-562-6900.

QUESTIONS?
If you have questions or need assistance, please call WSHIP Customer Service at **1-888-277-9135**.

ENCLOSURES:
- 2027 WSHIP Premium Rates for Medicare Plans
- Eligibility Verification Form (*return by December 15, 2026)*
- Bank Service Plan Authorization Form
- Return Envelope

IMPORTANT DEADLINES

December 7 is the deadline to enroll in a Medicare Advantage plan instead of WSHIP.

December 15 is the deadline to return your WSHIP Eligibility Verification Form to renew your current WSHIP plan or switch to WSHIP's lower-cost Medical Supplement plan.

Washington State Health Insurance Pool (WSHIP)
2027 Monthly Premium Rates

MEDICARE PLANS

		Plan			
Category	**Age**	**Basic**	**Basic Plus**	**Basic Plus Low Income[1]**	**Medical Supplement**
Full Premium	Under 65	$895	$1,201	$951	$691
	65+	$713	$958	$556	$551
You were enrolled in a prior medical benefit plan during the 63-day period prior to application to WSHIP with continuous enrollment for 18 months.	Under 65	$895	$1,201	$951	$691
	65+	$594	$798	$556	$460
You have been enrolled in WSHIP continuously for 36 months or more.	Under 65	$895	$1,201	$951	$691
	65+	$678	$910	$556	$524
You have been enrolled in WSHIP for 36 months or more AND had 18 months of continuous enrollment in a prior medical benefit plan.	Under 65	$895	$1,201	$951	$691
	65+	$565	$758	$556	$437

[1] You must submit documentation that you have qualified for Medicare Part D low income benefits and receive approval from WSHIP prior to being eligible for the Basic Plus Low Income rates.

WSHIP
WASHINGTON STATE HEALTH INSURANCE POOL

PO Box 780548
San Antonio, TX 78278
1-888-277-9135
WSHIP_Eligibility.T8@90degreebenefits.com

IMPORTANT
This form must be SIGNED and RETURNED by
DUE DATE: DECEMBER 15, 2026

WSHIP ELIGIBILITY VERIFICATION FORM (Medicare-Eligible 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

1. ***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:

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_____

   DSHS has more than one Medicaid option, a copy of your card is required to determine eligibility for WSHIP coverage.

   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

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 780548• San Antonio TX 78278

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 1-888-277-9135.

_____

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 780548
San Antonio, Tx 78278