FEDERAL
PRE-EXISTING CONDITION
INSURANCE PLAN

P. O. Box 1460
Little Rock, AR 72203

Applicant's Name

Application for Coverage Under the Federal High Risk Pool

administered by the Arkansas Comprehensive Health Insurance Pool (CHIP)

This Application for coverage through the Pre-Existing Condition Insurance Plan ("PCIP") contains an Eligibility Worksheet and an Enrollment Form. The Eligibility Worksheet explains who may be eligible for PCIP and asks questions to help you figure out if you are eligible for coverage. Please contact local PCIP Customer Service at 1-800-285-6477 if you have questions about the Application.

Please send your completed Eligibility Worksheet and Enrollment Form to: PCIP, c/o CHIP, P.O. Box 1460, Little Rock, AR 72203.

Send payment with your Application. Your first premium payment is due with this Application. Please review the Rate Sheet to determine the amount of your monthly premium. Failure to send your first premium payment along with the submission of your Application will delay processing. Premium payments may be monthly of quarterly, at your option.

SPECIAL NOTIFICATION

1. **PCIP is a temporary federal high risk pool anticipated to provide coverage from 9/1/10 through 12/31/13. The PCIP is funded solely by the federal government and enrollee premiums. Funds are limited.**
2. **PCIP is not funded by CHIP or the State of Arkansas.**
3. **Enrollment for PCIP in Arkansas will be capped at 2,500.**
4. **Individuals whose complete Applications are received after the cap of 2,500 has been reached will be placed on a waiting list and premiums will be returned.**
5. **Applications may only be submitted via U.S. Mail.**
6. **Applications will be processed on a first come, first serve basis—based on date of receipt by CHIP. Applications received on a particular day will be processed in the order of postmark date.**

ELIGIBILITY WORKSHEET

To be eligible for PCIP coverage in Arkansas you must:

1. Be a resident of Arkansas;

AND

2. Be a citizen or national of the United States or an alien lawfully present in the United States;

AND

3. Have not been covered under Creditable Coverage* at any point during the 6-month period prior to the date of this Application;

AND

4. During the past 6 months:

   - have been declined individual health coverage in Arkansas; or
   - have been offered individual health coverage in Arkansas with a rider excluding a pre-existing medical condition.

Eligibility questions begin on the next page.

* Question 3 on the following page describes the various forms of health coverage that are "Creditable Coverage" under federal law.

Applicant's Name

GENERAL ELIGIBILITY QUESTIONS

1. **Residency:** Are you a resident of the State of Arkansas?

   ❑ Yes ❑ No

   If you answered YES, you MUST attach proof of residency, then continue with question 2.

   Proof of residency includes written evidence such as a copy of your current driver's license, your most recent Arkansas tax return or your utility bill.

   If you answered NO, **STOP**. You are not eligible for PCIP coverage.

2. **Citizenship or Immigration Status.** Are you a citizen or national of the United States or an alien lawfully present in the United States? ❑ Yes ❑ No

   If you answered YES, you MUST attach proof of your status, then continue with question 3.

   - If a U.S. citizen, provide your Social Security Number on the application form that follows this Eligibility Worksheet.
   - If a U.S. national, provide a copy of a document that confirms your status as a noncitizen national, such as a copy of your U.S. passport.
   - If a lawfully present alien, you must provide a copy of your immigration document, including a document that has your Alien Registration Number or I-94 Number. Acceptable documents include a copy of the following:
     - o I-327 (Reentry Permit)
     - o I-551 (Permanent Resident Card
     - o I-571 (Refuge Travel Document)
     - o I-766 (Employment Authorization Document)
     - o Machine Readable Immigrant Visa (with Temporary I-551 language) affixed to Unexpired Foreign Passport
     - o I-94 (Arrival/Departure Record) with unexpired Foreign Passport
     - o Unexpired Foreign Passport for Visa Waiver Program travelers
     - o I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status) accompanied by I-94 and an Unexpired Foreign Passport
     - o DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status) accompanied by I-94 and an Unexpired Foreign Passport
     - o Other document with an I-94 or Alien Number

3. **Uninsured by Creditable Coverage within the last 6 months.** At any point in the last 6 months prior to the date you submit this application, have you had any of the following types of coverage? You must answer each question.
   - Individual or job-based health plan, including COBRA or conversion coverage? ❑ Yes ❑ No
   - Medicare (Part A and/or Part B)? ❑ Yes ❑ No
   - Medicaid? ❑ Yes ❑ No
   - ARKids or another state's Children's Health Insurance Program? ❑ Yes ❑ No
   - A state high risk pool such as the state plans offered by CHIP? ❑ Yes ❑ No
   - TRICARE (military health insurance) ❑ Yes ❑ No
   - Health insurance provided by a public health plan established by a state, the U.S. government such as coverage provided by the VA to veterans, or foreign country? ❑ Yes ❑ No
   - FEHBP (health insurance for Federal employees or retirees), including Temporary Continuation Coverage? ❑ Yes ❑ No
   - A health benefit plan provided to Peace Corps workers? ❑ Yes ❑ No
   - Services provided by the Indian Health Service or by a tribe or tribal organization for treating your medical condition? ❑ Yes ❑ No

     If you answered YES, **STOP**. You are not eligible for PCIP coverage.

     If you answered NO, continue with question 4.

4. **Proof of pre-existing condition(s).** In the last 6 months, have you been denied coverage by an Arkansas individual health insurer or HMO or been offered coverage by an Arkansas individual insurer or HMO with a rider excluding a particular medical condition or conditions? ❑ Yes ❑ No

If you answered NO, **STOP**. You are not eligible for PCIP coverage.

If you answered YES, you MUST provide the following proof of your difficulties obtaining coverage because of a pre-existing condition:

- **Notice of Rejection:** If you have been rejected or refused by an insurer or HMO to issue individual health coverage in Arkansas within the last 6 months because of the existence or history of a medical condition, please attach a copy of the rejection notice from the insurer or HMO and **fill out the Enrollment Form** beginning on the next page.
- **Offer of Individual Coverage with Exclusionary Rider:** If you were offered individual health coverage by an insurer or HMO in Arkansas that contained a rider excluding particular medical condition(s), please attach a copy of the offer and **fill out the Enrollment Form** beginning on the following page.

End of Eligibility Worksheet. Enrollment Form begins on next page.

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P.O. Box 1460
Little Rock, AR 72203

Enrollment Form

Please Print All Information.

APPLICANT INFORMATION

LAST NAME	FIRST NAME	M.I.	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	DEDUCTIBLE
						$1,000

MAILING ADDRESS AND CONTACT INFORMATION

Street or P.O. Box				Daytime Phone No.
City	State	Zip Code	County	Other Phone No.

RESIDENCE ADDRESS (If Different than Mailing Address)

Street			
City	State	Zip Code	County

E-mail address: _____

Would you like to receive information about your coverage from PCIP by e-mail? ❑ Yes ❑ No

BILLING MODE (Please Check One)

❑ Monthly Bank Draft (Monthly payment is by bank draft only. To sign up, you MUST sign the authorization form in your packet and submit a voided check. If you do not submit these items with your Application, you will be billed quarterly.)

❑ Quarterly (After initial billing with your acceptance letter, you will be billed for three months' premium due each January 1, April 1, July 1 and October 1.)

PERSONAL INFORMATION

Tobacco Use.

- If you do not answer the following question and are enrolled in PCIP, you will be charged the rates of a tobacco user.

Have you used tobacco products in the last 12 months, including any type of lighted pipe, cigar, cigarette or any other smoking equipment filled with tobacco, or any type of smokeless tobacco, such as snuff or chewing tobacco? ❑ Yes ❑ No

Disability

Do you receive Social Security Disability Insurance (SSDI)? ❑ Yes ❑ No If YES, list the date your SSDI began: _____

Have you filed for SSDI? ❑ Yes ❑ No If YES, list the date you filed: _____

IMPORTANT INFORMATION ABOUT BILLING AND PAYMENT

1. **Rates.** Your premiums may vary from other PCIP policyholders, depending on your age and whether you have used tobacco products in the last 12 months. Premium rates change on your "0" and "5" birthdays starting at age 30 (35, 40, 45, 50, etc.).
2. **Rate changes.** PCIP rates may change at other times as well. You will have 31 days' notice of any rate change.

CERTIFICATION

Please read carefully and sign on the next page at the end of this Certification..

I hereby apply for Pre-existing Condition Insurance Plan ("PCIP") coverage, as offered by the federal government and administered by CHIP in the State of Arkansas. I understand and agree to everything listed below:

- I certify that all the information I have provided in this Application (which includes the Eligibility Worksheet and this Enrollment Form) is true and complete. I understand that my coverage may be canceled or rescinded if CHIP determines that I have provided false information.
- I certify that as of the date I complete this Application, all information provided in the Eligibility Worksheet about residency, citizenship or immigration status, insurance coverage during the last six months and proof of pre-existing conditions is true and correct. I agree to cooperate with CHIP and its authorized subcontractors in verifying any and all information provided regarding my eligibility for this coverage.
- I have read and understand the Outline of Coverage provided with this Application.
- I understand that for my Application to be complete, I must submit all required documents necessary to verify information that has been provided in this Eligibility Worksheet and Enrollment Form. Failure to do so will delay processing of my Application and may affect enrollment into PCIP.
- I understand that if accepted, I will be issued a Policy that explains my rights and responsibilities as a PCIP enrollee and that failure to follow the requirements of the Policy may result in the cancelation of my coverage.

- I understand that if I do not pay premiums in full within 30 days after the due date, coverage will end as of the date payment was due.
- I understand that if I disenroll or my coverage is cancelled (for non-payment of premium, for example), I will not be able to reapply for enrollment for at least 6 months after my coverage ends, except when I lose coverage simply because I am moving from Arkansas to another state.
- I understand that if I obtain other health insurance, I am no longer eligible for PCIP and will immediately notify CHIP that I have other coverage.

Any person who knowingly presents false information in an Application for insurance, or knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and confinement in prison.

Signed at:	**City**	**State**	**ZIP**
Print Applicant's Name			
Applicant's Signature	**X**	**Date Signed**	

If you are a parent, legal guardian or authorized representative of the person applying for coverage, you must sign above and complete the information below:

LAST NAME	FIRST NAME	M.I.

MAILING ADDRESS AND CONTACT INFORMATION (if different from applicant)

Street or P.O. Box				Daytime Phone No.
City	State	Zip Code	County	Other Phone No.

My relationship to the person applying for coverage is: ❑ Parent ❑ Legal Guardian ❑ Other Authorized Representative
(We may require documentation of your relationship to the applicant)

Effective Date: Subject to availability of plan's enrollment limitations, an individual eligible for enrollment who submits a complete enrollment request by the 15th day of a month will have an effective date of the 1st day of the following month. A complete Application includes all required information and documentation required to complete processing.

Agent's Statement: I have a valid agent's or broker's license in the State of Arkansas for accident and health insurance. I have *assisted* the applicant in completing this Application for coverage in the Pre-Existing Condition Insurance Plan (PCIP). To the best of my knowledge and belief, the information contained in this Application and this affirmation statement is correct and complete. I certify that the applicant meets the PCIP eligibility standards.

Print Agent's Name	AR License No.	Social Security No.	Agency Name	AR License No.	Phone Number

Agent's Signature	Date	Address	City	St	ZIP

FOR OFFICE USE ONLY (Do NOT write in this space.)

Division No.: _____

Effective Date: _____

End of Enrollment Form. Mail this Enrollment Form with your Eligibility Worksheet to:

PCIP

c/o CHIP

P.O. Box 1460

Little Rock, Arkansas 72203