



# PCIP Supplemental Application Overview

California now offers a federally-funded Pre-Existing Condition Insurance Plan (PCIP), for medically-uninsurable Californians. The California Major Risk Medical Insurance Program (MRMIP) is a separate state program for medically uninsurables with different rules.

When you apply for the PCIP and/or MRMIP, your application will be reviewed for **both** health care programs to inform you of your coverage options. In order for your eligibility to be determined for **both** programs, you need to fill out both the PCIP supplemental application and the MRMIP application.

If you qualify for both programs, we will enroll you in the program you indicate that you prefer in Question 14, or we will contact you if you didn't respond to the question.

The MRMIP has an enrollment cap, which limits the number of individuals that can be enrolled. Applications will be processed on a first come, first served basis.

**Important Notice:** If you are currently or will be enrolled in the MRMIP, you **will not** qualify for the PCIP. The PCIP requires that an individual not have health insurance coverage for at least six (6) months, prior to receiving your application.

**Each** individual applying for the PCIP must complete their own application because the PCIP does not offer dependent coverage.

The PCIP and MRMIP have different eligibility rules, benefits and monthly premiums. The charts on the following page (page 2) compare the two programs.

**Questions?** You can visit [www.pcip.ca.gov](http://www.pcip.ca.gov) or [www.mrmib.ca.gov](http://www.mrmib.ca.gov) for more information  
Call **1-877-428-5060** Monday through Friday 8:00 AM – 8:00 PM, Saturday 8:00 AM – 5:00 PM.

## PCIP and MRMIP Eligibility Rules

Pre-Existing Condition Insurance Plan (PCIP) (Federal)	Major Risk Medical Insurance Program (MRMIP) (State)
<ul style="list-style-type: none"> <li>▪ Resident of California</li> </ul> <hr/> <ul style="list-style-type: none"> <li>▪ A pre-existing condition as shown by:               <ul style="list-style-type: none"> <li>♦ Rejection letter from a health insurance company in the last 12 months, <b>or</b></li> <li>♦ Offered coverage with premiums higher than those of the MRMIP preferred provider organization (PPO) in the geographic region where the individual is seeking coverage.</li> </ul> </li> </ul> <hr/> <ul style="list-style-type: none"> <li>▪ U.S. Citizen, U.S. National or lawfully present.</li> </ul> <hr/> <ul style="list-style-type: none"> <li>▪ No health insurance coverage in the last six months prior to application.</li> </ul> <hr/> <ul style="list-style-type: none"> <li>▪ Not enrolled in Medicare Part A &amp; Part B; or COBRA or Cal-COBRA benefits.</li> </ul> <hr/> <ul style="list-style-type: none"> <li>▪ Social Security Number required.</li> </ul> <hr/> <ul style="list-style-type: none"> <li>▪ Dependent coverage <b>not</b> available.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Resident of California</li> </ul> <hr/> <ul style="list-style-type: none"> <li>▪ A pre-existing condition as shown by:               <ul style="list-style-type: none"> <li>♦ Rejection letter from a health insurance company in the last 12 months, <b>or</b></li> <li>♦ Offer of premiums equal to or higher than those of the individual's first MRMIP plan choice, <b>or</b></li> <li>♦ Termination by an insurance carrier for reasons other than fraud or non-payment of premiums, ineligibility.</li> </ul> </li> </ul> <hr/> <ul style="list-style-type: none"> <li>▪ Not eligible for Medicare Part A or Part B (except for end stage renal disease), or COBRA or Cal-COBRA benefits.</li> </ul> <hr/> <ul style="list-style-type: none"> <li>▪ Social Security Number <b>not</b> required.</li> </ul> <hr/> <ul style="list-style-type: none"> <li>▪ Dependent coverage available.</li> </ul>

PCIP and MRMIP Benefits and Cost Comparison Chart	(Federal) PCIP	(State) MRMIP
<b>Annual deductible</b>	\$1,500	\$500
<b>Brand name drug deductible</b>	\$500	None
<b>Annual out of pocket maximum</b>	\$2,500	\$2,500
<b>Annual benefit cap</b>	None	\$75,000
<b>Lifetime benefit cap</b>	None	\$750,000
<b>Health care provider source</b>	PCIP PPO Network	Anthem Blue Cross, Contra Costa Health Plan, Kaiser
<b>Premium comparison chart</b>	See page 5 of this PCIP Supplemental application	See pages 16-21 of the MRMIP application
<b>Pre-existing condition exclusion period</b>	None	3 months

For more information on PCIP benefits, go to [www.pcip.ca.gov](http://www.pcip.ca.gov).

For more information on MRMIP benefits, go to [www.mrmib.ca.gov](http://www.mrmib.ca.gov).

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# PCIP Benefit Summary

The following summarizes the benefits provided by the PCIP. Some services are subject to limitations and/or prior authorization. All services are covered only when medically necessary. For specific benefit descriptions, refer to the PCIP Summary Plan Description Booklet on the web-site: [www.pcip.ca.gov](http://www.pcip.ca.gov).

## CALIFORNIA PRE-EXISTING CONDITION INSURANCE PLAN (PCIP)

### MEDICAL BENEFITS

Type of service	Subscriber Costs		Limitations and Explanations
	In-Network	Out-of-Network	
<b>Annual Deductible</b>	\$1,500	\$3,000	There are separate deductibles for in-network and out-of-network services.
<b>Coinsurance</b>	15%	50%	Coinsurance for services provided in-network is based on the Plan Allowance. Coinsurance for services provided out-of-network is 50% of the Plan Allowance plus any additional provider charges.
<b>Annual Out-Of-Pocket Maximum</b>	\$2,500	N/A	Includes in-network medical and brand name prescription drug deductibles, and any in-network co-payments and coinsurance. When a Subscriber reaches the annual maximum, the PCIP pays 100% of covered services in-network for the remainder of the calendar year. There is no out-of-pocket maximum for services received out-of-network.
<b>Preventive Care</b>	0%	50%*	Covered services include: routine physical examination and related laboratory services, routine gynecological examination, routine mammogram, routine Pap smear, Human Papillomavirus (HPV) screening, ovarian and cervical cancer screening, cytology examinations, family planning counseling services, health education services, prostate screening, hearing and vision examinations for children, newborn blood tests, sexually transmitted infections tests, Human Immunodeficiency Virus (HIV) testing, well baby and well child care, certain immunizations for adults and children, and disease management programs. In-network preventive care services are not subject to a deductible, copayment, or coinsurance. If you receive preventive care services from an out-of-network provider, you will have to pay any out-of-network deductible that you have not met and then 50% of the Plan Allowance plus any additional provider charges.
<b>Doctor Office Visit</b>	\$25	50%*	\$25 copayment for in-network office visits. In-network office visits are not subject to the annual deductible.
<b>Doctor Inpatient Visit</b>	15%*	50%*	Doctor visits while you are in the hospital.
<b>Inpatient Hospital Services</b>	15%*	50%*	Prior authorization is required. You must contact PCIP within 48 hours of an emergency admission.
<b>Inpatient Acute Rehabilitation</b>	15%*	50%*	Prior authorization is required.
<b>Outpatient Hospital Services</b>	15%*	50%*	Prior authorization is required for certain surgical procedures.
<b>Emergency Room Services</b>	15%*	15%*	Limited to treatment of a medical emergency. The in-network deductible, coinsurance, and out-of-pocket maximum apply to emergency services received from an out-of-network provider.

**CALIFORNIA PRE-EXISTING CONDITION INSURANCE PLAN (PCIP)**

**MEDICAL BENEFITS**

Type of service	Subscriber Costs		Limitations and Explanations
	In-Network	Out-of-Network	
<b>Ambulance</b>	15%*	15%*	Limited to a transport during a medical emergency. The in-network deductible, coinsurance, and out-of-pocket maximum apply to emergency services received from an out-of-network provider.
<b>Surgery &amp; Anesthesia</b>	15%*	50%*	Prior authorization is required for certain surgical procedures.
<b>Organ Transplants</b>	15%*	50%*	Some transplants must be performed in a Center of Expertise to receive the in-network benefit. Prior authorization is required.
<b>Blood &amp; Blood Products</b>	15%*	50%*	
<b>Cancer Clinical Trials</b>	15%*	50%*	Prior authorization is required.
<b>Outpatient Diagnostic X-ray &amp; Laboratory Services</b>	15%*	50%*	Prior authorization is required for certain radiological procedures.
<b>Family Planning Services</b>	15%*	50%*	Some birth control products are covered under the prescription drug benefit.
<b>Pregnancy and Maternity Care</b>	15%*	50%*	Includes prenatal care, delivery services and postpartum care.
<b>Infusion Therapy</b>	15%*	50%*	
<b>Physical Therapy</b>	15%*	50%*	
<b>Occupational Therapy</b>	15%*	50%*	Prior authorization is required.
<b>Speech Therapy</b>	15%*	50%*	Prior authorization is required.
<b>Skilled Nursing Facility</b>	15%*	50%*	Services are available only when determined to be a medically appropriate alternative plan of treatment that is cost effective. Prior authorization is required.
<b>Home Health Care</b>	15%*	50%*	Prior authorization is required.
<b>Hospice Care</b>	15%*	50%*	Prior authorization is required.
<b>Durable Medical Equipment</b>	15%*	50%*	Prior authorization is required for certain durable medical equipment.
<b>Orthotics and Prosthetics</b>	15%*	50%*	
<b>Inpatient Mental Health Care Services</b>	15%*	50%*	Inpatient treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances (SED) of a child has no day limits. All other inpatient mental health care is limited to 10 days each calendar year. Prior authorization is required.
<b>Outpatient Mental Health Care Services</b>	15%*	50%*	Outpatient treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances (SED) of a child has no visit limits. All other outpatient mental health care is limited to 15 visits each calendar year.
<b>Inpatient Alcohol and Substance Abuse Treatment</b>	15%*	50%*	Services are covered to remove toxic substances from the system. Prior authorization is required.
<b>Outpatient Alcohol and Substance Abuse Treatment</b>	15%*	50%*	Limited to 20 visits each calendar year. Additional visits may be available with prior authorization.

**CALIFORNIA PRE-EXISTING CONDITION INSURANCE PLAN (PCIP)**

**PRESCRIPTION DRUG BENEFITS**

<b>Prescription Drug</b>	<b>In-Network Pharmacy</b>	<b>Mail Order</b>	<b>Out-of-Network Pharmacy**</b>	<b>Limitations and Explanations</b>
<b>Annual Brand Name Drug Deductible</b>	\$500		\$500	There are separate deductibles for in-network and out-of-network pharmacies.
<b>Generic Drug Co-pay</b>	\$5	\$5	50%*	If you choose a brand-name drug for which a generic drug exists, you will pay the generic co-pay plus the difference between the cost of the brand-name drug and the cost of the generic drug, unless your doctor indicates medical necessity by writing "do not substitute" or "dispense as written" on the prescription order or by requesting and receiving prior authorization from PCIP.
<b>Preferred Brand Name Drug Co-pay</b>	\$15*	\$15*	50%*	
<b>Non-Preferred Brand Name Drug Co-pay</b>	\$30*	\$30*	50%*	
<b>Specialty Drugs</b>	N/A	\$30*	N/A	Specialty drugs require prior authorization.
<b>Maximum Supply</b>	30 days	90 days	30 days	

\* Annual brand name prescription drug deductible applies.

\*\* Subscriber pays the full cost of all drugs at an out-of-network pharmacy, PCIP reimburses the subscriber 50% of the charges for generic or brand name prescription drug after the subscriber submits a claim.

**California PCIP Subscriber Premiums**  
Effective Through December 31, 2011

<b>Age band</b>	<b>Region 1</b>	<b>Region 2</b>	<b>Region 3</b>	<b>Region 4</b>	<b>Region 5</b>	<b>Region 6</b>
< 15	\$ 145	\$ 138	\$ 140	\$ 127	\$ 142	\$ 127
15 – 29	\$ 199	\$ 195	\$ 201	\$ 180	\$ 200	\$ 181
30 – 34	\$ 286	\$ 282	\$ 292	\$ 258	\$ 288	\$ 260
35 – 39	\$ 319	\$ 314	\$ 325	\$ 288	\$ 321	\$ 289
40 – 44	\$ 337	\$ 332	\$ 344	\$ 304	\$ 339	\$ 306
45 – 49	\$ 369	\$ 364	\$ 377	\$ 334	\$ 371	\$ 335
50 – 54	\$ 494	\$ 481	\$ 499	\$ 445	\$ 495	\$ 448
55 – 59	\$ 627	\$ 608	\$ 624	\$ 564	\$ 625	\$ 567
60 – 64	\$ 796	\$ 780	\$ 802	\$ 720	\$ 799	\$ 723
65 – 69	\$ 891	\$ 873	\$ 899	\$ 806	\$ 895	\$ 810
70 – 74	\$ 939	\$ 920	\$ 947	\$ 849	\$ 943	\$ 853
> 74	\$ 995	\$ 975	\$1,003	\$ 899	\$ 999	\$ 904

**PCIP geographic regions:** Counties in each region

**Region 1 Northern:** Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba

**Region 2 Valley:** Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus

**Region 3 Bay Area:** Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara

**Region 4 South Coast:** Orange, Santa Barbara, Ventura

**Region 5 Los Angeles:** Los Angeles

**Region 6 South:** Riverside, San Bernardino, San Diego

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# PCIP Supplemental Application Checklist

1. Please use the following checklist as you complete **both** the supplemental application **and** MRMIP application. The PCIP Supplemental Application is pages 7 – 9 of this document, **and** the MRMIP Application is pages 23 – 26 of the MRMIP Handbook.
    - Review** the PCIP and MRMIP comparison charts on page 2. The charts provide information about the different PCIP and MRMIP eligibility rules and benefits.
    - Complete** all questions on **both** applications, as they must be fully answered. If you do not provide all necessary information (including the required documentation, social security number, signature, and payment), the processing of your application will be delayed.
    - Sign and date** the completed PCIP Supplemental Application **and** the MRMIP Application.
  2. **Attach** the following items below:
    - Supporting documentation** that indicates your eligibility for the PCIP and MRMIP.
      1. Proof of citizenship or immigration status.
      2. a) Copy of rejection letter for individual insurance coverage within the previous 12 months; or  
b) Copy of letter indicating individual coverage has been offered in excess of the MRMIP preferred provider organization (PPO) monthly premiums, in the geographic region where you reside. See MRMIP PPO monthly premiums on pages 16 – 21 of the MRMIP Handbook.
    - A check** for one month's premium must be made payable to the **Managed Risk Medical Insurance Board (or MRMIB)** for the program you prefer on Question 14. (PCIP Monthly premiums are listed on page 6 of this document and MRMIP monthly premiums are on pages 16 – 21 of MRMIP Handbook). If you owe more money because you are not eligible for your preferred program, we will contact you. Under payment of premium will delay the processing of your application.
  3. **Mail** the completed PCIP Supplemental Application **and** MRMIP Application **with** your check and all necessary supporting documents to:

California Pre-Existing Condition Insurance Plan  
P.O. Box 537032  
Sacramento, CA 95853-7032

Please be sure to send the correct premium for the program you prefer.
- ★ **Insurance agents or brokers:** You must complete **all** boxes at the bottom of page 23 of the MRMIP Application to request reimbursement.

**Questions?** You can visit [www.pcip.ca.gov](http://www.pcip.ca.gov) or [www.mrmib.ca.gov](http://www.mrmib.ca.gov) for more information  
Call **1-877-428-5060** Monday through Friday 8:00 AM – 8:00 PM, Saturday 8:00 AM – 5:00 PM.



# PCIP Supplemental Application

1. Applicant's last name		Applicant's first name					
2. Applicant's mailing address							
City			State				
			Zip code				
3. Applicant's phone number (    )	4. Applicant's birth date (mm/dd/yyyy)	5. Are you a California resident? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<p>6. Are you a U.S. citizen or U.S. national? <input type="checkbox"/> Yes <input type="checkbox"/> No  <i>If <b>no</b>, skip to Question 7.</i></p> <p><b>A.</b> If <b>yes</b>, you must send a copy of one of the following:  <input type="checkbox"/> Birth certificate    <input type="checkbox"/> Passport    <input type="checkbox"/> Certificate of U.S. citizenship or naturalization    <input type="checkbox"/> Other proof of citizenship  For U.S. Nationals, make sure you send papers that are not expired. Include copies of the front and back sides.</p> <p><b>B.</b> Social Security Number (required):  <i>Skip to Question 8 after filling in 6B above.</i></p>							
7. Are you lawfully residing in the U.S.? <i>If <b>yes</b>, you must send proof of immigration status that shows the expiration date and is not expired. Include copies of the front and back sides.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No							
8. Have you received a denial letter from a health insurance company within the past 12 months because of a medical condition? <i>If <b>yes</b>, provide a copy of the <b>denial letter</b>.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No							
9. Have you received an offer of individual health insurance coverage within the past 12 months at higher rates than the MRMIP PPO Product? <i>If <b>yes</b>, provide a copy of the <b>offer letter</b>.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No							
<p>10. Within the past 6 months, have you had any of the following types of health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No  Please indicate by checking the boxes below.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> Individual or job-based health plan, including COBRA Cal-COBRA  <input type="checkbox"/> Medicare Part A and/or Part B  <input type="checkbox"/> Medicaid  <input type="checkbox"/> Medicaid  <input type="checkbox"/> Children's Health Insurance Program (or CHIP)  <input type="checkbox"/> A state high risk pool  <input type="checkbox"/> TRICARE (military health insurance)  <input type="checkbox"/> Health benefit plan provided to Peace Corps workers </td> <td style="width: 50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> Health coverage provided by a public health plan or established by a state, the U.S. government, such as coverage provided to veterans enrolled in VA health care, or a foreign country  <input type="checkbox"/> FEHBP (health insurance for Federal employees or retirees), including Temporary Continuation of Coverage (TCC)  <input type="checkbox"/> Services provided by the Indian Health Service or by a Tribe or Tribal organization for treating your medical condition </td> </tr> </table> <p>If you had health insurance within the past 6 months, please provide the reason your health insurance coverage ended:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> You or someone in your family lost or left their job  <input type="checkbox"/> Your insurance company stopped covering dependents  <input type="checkbox"/> You or someone in your family stopped working full-time and were no longer eligible for benefits  <input type="checkbox"/> You moved out of the insurance company's service area  <input type="checkbox"/> Other. Explain the reason your coverage ended: _____  _____  _____ </td> <td style="width: 50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> Your insurance premiums were too high  <input type="checkbox"/> Your COBRA coverage ended  <input type="checkbox"/> You voluntarily ended your insurance coverage  <input type="checkbox"/> You are no longer eligible for publicly-sponsored coverage </td> </tr> </table>				<input type="checkbox"/> Individual or job-based health plan, including COBRA Cal-COBRA <input type="checkbox"/> Medicare Part A and/or Part B <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicaid <input type="checkbox"/> Children's Health Insurance Program (or CHIP) <input type="checkbox"/> A state high risk pool <input type="checkbox"/> TRICARE (military health insurance) <input type="checkbox"/> Health benefit plan provided to Peace Corps workers	<input type="checkbox"/> Health coverage provided by a public health plan or established by a state, the U.S. government, such as coverage provided to veterans enrolled in VA health care, or a foreign country <input type="checkbox"/> FEHBP (health insurance for Federal employees or retirees), including Temporary Continuation of Coverage (TCC) <input type="checkbox"/> Services provided by the Indian Health Service or by a Tribe or Tribal organization for treating your medical condition	<input type="checkbox"/> You or someone in your family lost or left their job <input type="checkbox"/> Your insurance company stopped covering dependents <input type="checkbox"/> You or someone in your family stopped working full-time and were no longer eligible for benefits <input type="checkbox"/> You moved out of the insurance company's service area <input type="checkbox"/> Other. Explain the reason your coverage ended: _____ _____ _____	<input type="checkbox"/> Your insurance premiums were too high <input type="checkbox"/> Your COBRA coverage ended <input type="checkbox"/> You voluntarily ended your insurance coverage <input type="checkbox"/> You are no longer eligible for publicly-sponsored coverage
<input type="checkbox"/> Individual or job-based health plan, including COBRA Cal-COBRA <input type="checkbox"/> Medicare Part A and/or Part B <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicaid <input type="checkbox"/> Children's Health Insurance Program (or CHIP) <input type="checkbox"/> A state high risk pool <input type="checkbox"/> TRICARE (military health insurance) <input type="checkbox"/> Health benefit plan provided to Peace Corps workers	<input type="checkbox"/> Health coverage provided by a public health plan or established by a state, the U.S. government, such as coverage provided to veterans enrolled in VA health care, or a foreign country <input type="checkbox"/> FEHBP (health insurance for Federal employees or retirees), including Temporary Continuation of Coverage (TCC) <input type="checkbox"/> Services provided by the Indian Health Service or by a Tribe or Tribal organization for treating your medical condition						
<input type="checkbox"/> You or someone in your family lost or left their job <input type="checkbox"/> Your insurance company stopped covering dependents <input type="checkbox"/> You or someone in your family stopped working full-time and were no longer eligible for benefits <input type="checkbox"/> You moved out of the insurance company's service area <input type="checkbox"/> Other. Explain the reason your coverage ended: _____ _____ _____	<input type="checkbox"/> Your insurance premiums were too high <input type="checkbox"/> Your COBRA coverage ended <input type="checkbox"/> You voluntarily ended your insurance coverage <input type="checkbox"/> You are no longer eligible for publicly-sponsored coverage						

<b>11.</b> Has your employer or an insurance company discouraged you from obtaining health insurance coverage that you were eligible for? <i>If yes, please provide more information below:</i> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
Name of employer or health insurance company:		
Employer or health insurance company address:		
City	State	Zip code
<b>12.</b> What language do you want us to speak to you in?		
<b>13.</b> What language should we write to you in?		
<b>14.</b> If you are eligible for both PCIP and MRMIP, indicate your preference for enrollment. <i>If you do not indicate your preference you will be enrolled into the PCIP.</i> <span style="float: right;">(check <b>only one</b> box): <input type="checkbox"/> PCIP <input type="checkbox"/> MRMIP</span>		

## Important Notices and Declarations

- I understand that it is my responsibility to inform PCIP of any health insurance coverage I get in the future or if I move out of California, so that I can be disenrolled.
- I understand that if I voluntarily disenroll from PCIP or if I am disenrolled involuntarily (for example, for failure to pay my premiums on time), I may not re-apply for enrollment until at least 6 months after my coverage ends.
- I understand and agree to the release of the application information to PCIP.
- I understand that my application and enrollment information may be shared with other government agencies for purposes of establishing eligibility for the PCIP.
- I declare that I have read and understand the information on this Supplemental Application and agree to these Notices and Declarations.

I certify that the information provided on this supplemental application is true, complete and correct to the best of my knowledge.

Applicant signs here **(required)** : \_\_\_\_\_ Date \_\_\_\_\_

## Permission to Share PCIP Information

I give permission for the Pre-Existing Condition Insurance Plan (PCIP) to give information over the telephone about the status of my PCIP application to the person listed below. This permission will end on the date the program mails its decision on the application.

Person's Name: \_\_\_\_\_  
Please print first and last name

Agent/Broker CA License Number (if applicable): \_\_\_\_\_

**Applicant's Signature:** ➔ \_\_\_\_\_ **Date:** \_\_\_\_\_

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