



Health Insurance Plan of Iowa
FedPCIP

HIPIOWA-FED, LLC

Administered by: Benefit Management, Inc. (BMI) ♦ P.O. Box 1090 ♦ Great Bend, Kansas 67530

Toll-Free number 1-877-505-0513

Fax number 1-877-505-0522

APPLICATION FOR COVERAGE

HIPIOWA-FED, LLC

Please type or **PRINT** in black ink. All sections must be filled out completely. **Your premium and required documents should be included with your signed application.** Timely and complete submission of all documents will expedite the enrollment process. **You must be a resident of the state of Iowa and meet other eligibility criteria to apply.** (Your application may be faxed to 1-877-505-0522; original application and premium must be sent by mail within 5 business days to HIPIOWA-FED, LLC, 2015 16th Street, PO Box 1090, Great Bend, KS 67530.)

AGENT INFORMATION

If you are applying through an Agent, the Agent must provide the information below and sign this section.

Agent Name				Firm or Agency			
Agent Street Address				City		State	Zip Code
Agent Phone ()				Agent Email Address			
Agent's Iowa State License Number				<input type="checkbox"/> Copy of current license attached* <input type="checkbox"/> Copy of current license on file with HIPIOWA-FED, LLC* <i>* Must be attached or on file to receive agent commission</i>			
Agent/Agency Tax I.D. Number				<input type="checkbox"/> Pay commission to firm <input type="checkbox"/> W-9 form attached <input type="checkbox"/> Pay commission to agent <input type="checkbox"/> W-9 form on file with HIPIOWA-FED, LLC			
Agent Statement: I certify I have verified that all persons applying for coverage are eligible. I further certify, to the best of my knowledge, the information on this application has been completed truthfully by the applicant.							
Agent Signature: X _____						Date Signed: _____	

APPLICANT IDENTIFICATION

Social Security Number		First Name		Middle Initial	Last Name	
Date of Birth (Month, Day, Year)		Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Mailing Address		
Daytime Phone Number ()		County		(City, State, Zip Code + 4)		

PLAN ELECTION

\$1,000 Deductible

Have you smoked cigarettes, cigars, or pipes or used chewing tobacco or other tobacco products in the last 12 months?

Yes No (If no, you must complete the Non-Tobacco User Affidavit to receive the lower, non-user rate.)

ELIGIBILITY

ELIGIBILITY CERTIFICATION:

I certify that I am eligible for this coverage as I meet the following conditions: (Please check all that apply to you):

1. Yes No I am currently a resident of the State of Iowa.

(Attach a copy of one of the following :)

- A bill in your name from any public utility at your dwelling in the state of Iowa;
- Receipts for rent, mortgage or lease payments for your dwelling in Iowa;
- An Iowa driver's license or state identification card;
- Proof of registration and payment in Iowa of taxes and fees on motor vehicles;
- A voter registration card; or
- A copy of your State of Iowa tax return.

2. Yes No I attest that I am a citizen or national of the United States or am lawfully present in the United States.

(Attach a copy of one of the following :)

- U.S. passport;
- Birth certificate;
- Certificate of U.S. citizenship;
- Naturalization certificate;
- Tribal document from a federally-recognized Indian tribe;
- Documentation confirming status as a national, such as a copy of a U.S. passport that shows national status;
- I-327 (Reentry Permit);
- I-551 (Permanent Resident Card);
- I-571 (Refugee Travel Document);
- I-766 (Employment Authorization Card) accompanied by either an I-94 and an Unexpired Foreign Passport or an I-797 (Notice of Action);
- Machine Readable Immigrant Visa (with temporary I-551 language) affixed to Unexpired Foreign Passport;
- I-94 Arrival/Departure Record with Unexpired Foreign Passport;
- Unexpired Foreign Passport;
- I-20 Certificate of Eligibility for Nonimmigrant (F-1) Student Status accompanied by I-94 and an Unexpired Foreign Passport;
- DS2019 Certificate of Eligibility for Exchange Visitor (J-1) Status accompanied by I-94 and an Unexpired Foreign Passport; or
- Other document with an I-94 or Alien Number.

You must be able to answer "yes" to one of the next 3 questions 3, 4, or 5 below, and provide the required documentation.

- **Attach a copy of your proof of condition statement for question number 3.**
- **Attach a copy of the rider or endorsement letter excluding coverage for question number 4.**
- **Attach a copy of the declination letter for question number 5.**

3. Yes No Have you been diagnosed with one of the following pre-qualifying condition(s)?
 (If you have any of the conditions listed on the Conditions List you will not be required to submit a declination letter from another insurance carrier.)

Conditions List

Indicate the diagnosed conditions below and attach a statement from your physician substantiating the conditions.

- | | | |
|--|---|---|
| <input type="checkbox"/> Acquired Immune Deficiency syndrome | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Open Heart Surgery |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Intermittent Claudication | <input type="checkbox"/> Paraplegia or Quadriplegia |
| <input type="checkbox"/> Arteriosclerosis Obliterans | <input type="checkbox"/> Juvenile Diabetes | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Kidney Failure requiring dialysis | <input type="checkbox"/> Peripheral Arterioscler-treat w/3yrs |
| <input type="checkbox"/> Ascite | <input type="checkbox"/> Lead Poisoning w/Cerebral Invol | <input type="checkbox"/> Polyarteritis (periarteri nodosa) |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Postero-lateral Sclerosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Lupus | <input type="checkbox"/> Psychotic Disorders |
| <input type="checkbox"/> Cirrhosis of the Liver | <input type="checkbox"/> Malignant Tumor(treat w/4 yrs) | <input type="checkbox"/> Silicosis |
| <input type="checkbox"/> Coronary Insufficiency | <input type="checkbox"/> Metastatic Cancer | <input type="checkbox"/> Splenic Anemia(true banti's syn) |
| <input type="checkbox"/> Coronary Occlusion | <input type="checkbox"/> Motor or Sensory Aphasia | <input type="checkbox"/> Still's Disease |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Multiple or Disseminated Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dermatomyositis | <input type="checkbox"/> Muscular Atrophy or Dystrophy | <input type="checkbox"/> Syringomyelia Tabes Dorsalis |
| <input type="checkbox"/> Friedrich's Disease | <input type="checkbox"/> Myasthenia Gravis | <input type="checkbox"/> Topectomy and Lobotomy |
| <input type="checkbox"/> Huntington's Disease | <input type="checkbox"/> Myotonia | <input type="checkbox"/> Wilson's Disease |

4. Yes No I have been offered health insurance coverage with a rider or endorsement that excludes coverage for a specified condition. **(Attach a copy of the insurance offer showing the exclusion.)**

5. Yes No I have been denied coverage due to a pre-existing health condition.
(Attach a copy of the declination letter.)

In order to qualify for the HIPIOWA-FED, LLC high risk pool program you must have been without substantial health coverage (known as Creditable Coverage) for at least six months. Please reference the included document entitled "Creditable Coverage for purposes of the Federal High Risk Pool" for a complete list of what may be considered creditable coverage.

6. Yes No I attest that I have not been covered under any health coverage defined as Creditable Coverage for a continuous 6-month period of time prior to the date on which I am applying for coverage (benefit plan effective date) under HIPIOWA-FED, LLC.

(Please enter the last date on which you had health coverage, the type of coverage and the name of the carrier or plan. Include a copy of your Certificate of Creditable Coverage if you have it.)

Date coverage terminated: _____ Name of Carrier/Plan: _____ Type of Coverage: _____
 (ex. Group or Individual)

Group Available Coverage

Current employer name _____ Is group coverage available? Yes No

If you checked yes, why have you not elected group coverage? _____

Current family member(s) employer name _____ Is group coverage available? Yes No

If you checked yes, why have you not elected group coverage? _____

Has your current employer or family member(s) employer recently terminated their group health insurance coverage? Yes No

Is any portion of your HIPIOWA-FED, LLC premium going to be paid by your employer or family member(s) employer or is your employer reimbursing you for any portion of your HIPIOWA-FED, LLC premium? Yes No

EFFECTIVE DATE AND PREMIUM PAYMENT METHOD

Coverage Effective Date – Unless a future date is requested, applications postmarked on or before the 15th day of the month will be given an effective date of the 1st of the month immediately following the postmark date. Applications postmarked after the 15th of the month will be given an effective date of the 1st day of the **second** month which follows the postmark date.

Premium Payment Method:	<input type="checkbox"/> Monthly Invoice – Include a check for the first month’s premium with your application
	<input type="checkbox"/> Monthly automatic bank debit – Include a check for first month’s premium with your application and complete the attached “Authorization Agreement for Preauthorized Payment.”

Monthly premium payments are due the first of each month. Please note, whether paying by monthly invoice or monthly automatic bank debit, a check for the first month’s premium must be included with your application. Please use the following table to indicate the correct monthly premium.

To determine your premium, refer to the enclosed premium rate sheet and locate your rate based on your current age and tobacco use status.	Amount
Total amount of monthly premium due	\$

A check made payable to HIPIOWA-FED, LLC for your first premium is submitted with this application. If you selected to pay premium via monthly automatic bank debit, your next month’s premium will be debited from your account.

I represent that my answers and statements on this application are true and complete to the best of my knowledge. I understand that if they are not, my benefit plan may not be valid and I may be subject to prosecution for fraud. I understand that I must notify HIPIOWA-FED, LLC immediately upon the change in any of the information contained in the application. I understand that all hospitalizations and certain other procedures as specified in my benefit plan must be pre-certified or benefits will be reduced. I authorize providers of health care to furnish the administrator with medical information to the extent necessary for processing this application or claims.

Applicant’s Signature _____ **Date** _____

IMPORTANT NOTICE: Any person who supplies false information in this application or in any application, claim or other matter with respect to HIPIOWA-FED, LLC (or who assists or encourages any other person to do so), may be subject to prosecution for fraud. Penalties may include fines, license suspension or revocation, and imprisonment.



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HIPIOWA-FED, LLC

I certify that I understand the following:

1. HIPIOWA-FED, LLC is under contract with the federal government;
2. The contract with the federal government expressly dictates the design, implementation, and operational standards and requirements of HIPIOWA-FED, LLC consistent with the Patient Protection and Affordable Care Act and funding limitations set forth in the Act;
3. The federal government has reviewed and expressly approved the design, implementation, and operational standards and requirements for HIPIOWA-FED, LLC;
4. HIPIOWA-FED, LLC is funded solely through premiums paid by participants in HIPIOWA-FED, LLC and through authorized federal funds;
5. The Patient Protection and Affordable Care Act requires the Secretary of the Department of Health and Human Services to estimate the amount of federal funds available to pay the expenses of all state high risk pools and to make adjustments to eliminate any deficit in such funds; however because the only sources of money to pay for the costs of HIPIOWA-FED, LLC are federal funds and premiums, in the event federal funds and premiums are not sufficient to pay the costs of the program the applicant's coverage in HIPIOWA-FED, LLC will terminate;
6. The State of Iowa is not in any way responsible for funding the payment of claims or any other costs of HIPIOWA-FED, LLC; and
7. There is a risk that claims may not be paid if federal funds and premiums collected are insufficient to cover claims.

Applicant's Signature _____ **Date** _____

I agree not to sue the State of Iowa or their representatives for any action related to the design, implementation, operation, or administration of HIPIOWA-FED, LLC including the denial of participation or eligibility in HIPIOWA-FED, LLC and the denial or nonpayment of a claim.

Applicant's Signature _____ **Date** _____



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Non-Tobacco User Affidavit

Under penalty of perjury, I declare that I neither (i) presently smoke or use tobacco products*, nor (ii) have smoked or used tobacco products at any time during the 12 months immediately preceding the date of this affidavit. I understand that if I falsely claim the non-tobacco user discount on my application for health coverage, I am subject to prosecution under applicable laws (the penalties for a false claim may include criminal charges and/or fines), an obligation to pay the additional premium required of tobacco users and the denial of any claim under the health benefit plan for which I am applying.

*("Smoke or use tobacco products" for purposes of this affidavit means any use of cigarettes, pipes, cigars, smokeless tobacco, or any other tobacco products regardless of the number of times, frequency or method of use).

I, the applicant, have read the above and understand the penalties that may apply if my statements are false.

Date: _____ Printed Name: _____ Signature: _____



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HIPIOWA-FED, LLC
AUTHORIZATION AGREEMENT FOR PREAUTHORIZED PAYMENTS

Member: _____

Member Number: _____

(Not required for new enrollees)

I hereby authorize HIPIOWA-FED, LLC, hereinafter called COMPANY, to initiate debit entries to my account indicated below, and the depository named below, hereinafter called DEPOSITORY, to debit same to such account.

(Select one): Checking Savings account

BANK NAME: _____

CITY: _____ STATE: _____ ZIP: _____

TRANSIT/ABA NO.: _____ ACCOUNT NO.: _____

This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME: _____

DATE: _____ SIGNED: _____

Note: Person signing this form must also be on the signature card with the bank for this account.

Debit entries will occur on the 1st day of the month. If the date falls on a weekend or holiday, the debit entry will occur on the first business day thereafter. All changes, including stop draft orders, must be received by the 15th of the prior month in which the premium is due. Requests received after that date cannot be honored for the next payment due date.

**Attach a voided check from
the account to be debited
here.**



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Creditable coverage for purposes of the Federal High Risk Pool

Creditable Coverage is any public or private health insurance or health benefit plan, whether insured or self-insured. The following types of health care coverage are Creditable Coverage:

1. A group health benefit plan;
2. Individual or group health insurance coverage;
3. Medicare - Part A or Part B of Title XVIII of the Social Security Act;
4. Medicaid - Title XIX of the Social Security Act;
5. Medical and dental care for members and certain former members (and their dependents) of the armed forces, the Commissioned Corps of the National Oceanic and Atmospheric Administration, and the Public Health Service under Chapter 55 of Title 10, United States Code;
6. A medical care program of the Indian Health Services or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under the Federal Employees Health Benefits Program (FEHBP) (Chapter 89 of Title 5, United States Code);
9. A public health plan established or maintained by a state, a foreign country, the U.S. government, or other political subdivision of a state, the U.S. government or foreign country that provides health insurance coverage;
10. A health benefit plan provided under the Peace Corps Act (22 U.S.C. 2504(e));
11. A State Children's Health Insurance Program (CHIP) whether it is a stand-alone separate program, a CHIP Medicaid expansion program, or a combination program, and whether it is provided through a group health plan, health insurance, or any other mechanism.

Health coverage provided under the following is not Creditable Coverage:

- (a) accident-only or disability income insurance;
- (b) coverage issued as a supplement to liability insurance;
- (c) liability insurance, including general liability insurance and automobile liability insurance;
- (d) worker's compensation insurance;
- (e) automobile medical-payment insurance;
- (f) coverage for on-site medical clinics;

- (g) other similar insurance coverage (specified in certain rules) under which benefits for medical care are secondary to other insurance benefits;
- (h) if offered separately and not as part of larger health coverage:
 - (1) limited scope dental or vision benefits;
 - (2) long-term care coverage, nursing home care coverage, home health care coverage, community-based care coverage or any combination of these;
 - (3) prescription drug benefits only; or
 - (4) other similar, limited benefits;
- (i) if offered as independent, non-coordinated benefits:
 - (1) specified disease or illness benefits; or
 - (2) hospital or surgical indemnity benefits;
- (j) if offered as a separate insurance policy, Medicare supplemental health insurance, coverage supplemental to the coverage described in #5 above (that provided under Chapter 55 of Title 10, United States Code), and similar supplemental coverage.

HIPIOWA-FED		
2011 Premium Rates for the \$1,000 Deductible Plan		
Attained Age	Non Tobacco User	Tobacco User
0 - 17	\$155.62	\$179.74
18	\$167.86	\$193.88
19	\$183.97	\$212.49
20	\$201.84	\$233.12
21	\$216.13	\$249.62
22	\$230.43	\$266.15
23	\$234.96	\$271.38
24	\$240.54	\$277.82
25	\$245.76	\$283.86
26	\$249.25	\$287.88
27	\$249.60	\$288.29
28	\$256.58	\$296.86
29	\$261.11	\$302.62
30	\$263.54	\$305.97
31	\$265.29	\$308.53
32	\$268.42	\$312.71
33	\$275.04	\$320.98
34	\$281.67	\$329.26
35	\$288.29	\$337.59
36	\$295.28	\$346.36
37	\$299.64	\$352.08
38	\$305.20	\$358.92
39	\$311.39	\$366.51
40	\$318.41	\$375.09
41	\$325.50	\$383.76
42	\$332.79	\$392.69
43	\$341.01	\$403.07
44	\$349.63	\$413.96
45	\$358.41	\$425.07
46	\$367.43	\$436.51
47	\$373.86	\$444.89
48	\$382.01	\$456.12
49	\$390.23	\$467.50
50	\$398.48	\$478.97
51	\$406.87	\$490.69
52	\$414.89	\$502.02
53	\$426.87	\$518.22
54	\$438.45	\$534.03
55	\$450.00	\$549.90
56	\$462.05	\$566.47
57	\$475.19	\$584.48
58	\$492.23	\$605.44
59	\$509.57	\$626.77
60	\$527.27	\$648.54
61	\$545.78	\$671.31
62	\$565.08	\$695.05
63	\$583.45	\$717.64
64	\$602.78	\$741.42
65+	\$622.45	\$765.61

Age/Rate is calculated as of age upon enrollment, and then is the attained age every January 1st thereafter.



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HIPIOWA-FED, LLC APPLICATION CHECKLIST

Please review this checklist to ensure that your application is completed in entirety.

- If you used an agent/broker, has he or she:
 - Completed the Agent Information section;
 - Attached a W-9; or
 - Enclosed a copy of their agent license?

- Did you check the box for the health care plan option in the Plan Election section of the application?

- Tobacco Statement from another State.

- Have you checked the box for Iowa residency, and provided proof?

- If you are a citizen, or national of the United States, or an alien lawfully present in the United States, have you attached the required documentation? (See #2 under the Eligibility Certification section)

- Have you provided proof of a pre-existing condition under Eligibility Certification by answering “yes” to question 3, 4 or 5 and attached the supporting documentation required?
 - If you answered “yes” to question 3, have you marked all medical conditions on the Conditions List that pre-qualify you for HIPIOWA-FED, LLC and attached a copy of your physician’s statement?
 - If you answered “yes” to question 4, have you included a copy of the rider or endorsement that indicates the specified condition exclusion?
 - If you answered “yes” to question 5, have you included a copy of the declination letter from the other insurance company?

- Did you enter the following on question number 6;
 - Date of last coverage;
 - Name of Carrier/Plan; and
 - Type of Coverage (ex. Group or Individual)?

- Did you choose a payment option? (Monthly Invoice or Monthly Automatic Bank Debit)

- If you chose the Monthly Automatic Bank Debit, did you complete, sign and enclose the “Authorization Agreement for Preauthorized Payments” form and attach a voided check?

- Regardless of which payment method you chose, did you enclose a check for your first month’s premium?

- Did you sign and date the application?

- Did you sign and date the certification page?

- If you want to allow others to access your personal health or financial information, did you complete, sign and enclose the “Authorization to Release Protected Health Information and Protected Financial Information?”

If you have questions about the application or need additional information, please contact our Customer Service Department at 1-877-505-0513. Application may be faxed to 1-877-505-0522; Original application and premium payment must be sent by mail within 5 business days to the following address: HIPIOWA-FED, LLC, 2015 16th Street, PO Box 1090, Great Bend, KS 67530.