



Administered by BMI P.O. Box 1090 Great Bend, Kansas 67530 Toll-Free number 1-877-505-0508

**NHHP-FED**

**APPLICATION FOR COVERAGE**

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 may fax your application if the original application and premium payment are mailed within 5 days to fax 1-877-505-0522.) **You must be a resident of the state of New Hampshire and meet other eligibility criteria to apply.**

<b>PRODUCER INFORMATION</b>		<i>If you are applying through a Producer, the Producer must provide the information below and sign this section.</i>	
Producer Name	Firm or Agency		
Producer Street Address	City	State	Zip Code
Producer Phone ( )	Producer Email Address		
Producer's New Hampshire State License Number	<input type="checkbox"/> Copy of current license attached* <input type="checkbox"/> Copy of current license on file with NHHP-FED* <i>* Must be attached or on file to receive producer commission</i>		
Producer/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 producer <input type="checkbox"/> W-9 form on file with NHHP-FED		
Producer 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.			
Producer Signature: X _____		Date Signed: _____	

<b>APPLICANT IDENTIFICATION</b>			
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**

Please Choose One Plan:

Indemnity Option A      \$2,000 Deductible  
 Managed Care Option A      \$1,000 Deductible  
 Managed Care Option B      \$2,500 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.)

**Please Note: If the Answer is “Yes” to questions A or B below, you are not eligible for coverage and should not complete the remainder of this application. If the Answer is “No” to questions A and B below, please continue completing the application.**

A.  Yes  No Are you covered by or eligible for Medicare, Medicaid or Title XXI (NH Healthy Kids)?

B.  Yes  No Are you eligible for health coverage through your employer or the employer of your spouse, partner by civil union or parent?

**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 a NH resident (**Please sign the attached copy of the Residency Affidavit**).

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;
- U.S. Birth certificate or Certificate of U.S. Birth Abroad;
- Certificate of U.S. citizenship;
- Certificate of U.S. naturalization;
- Native American tribal document from a federally-recognized tribe;
- Documentation confirming status as a national, such as a copy of a U.S. passport that shows national status;
- I-197 (U.S. Citizen ID card);
- I-179 (ID card for use by a resident citizen);
- 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 accompanied by other documentation evidencing lawful presence in the U.S.;
- 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.

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**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 3**
- **Attach a copy of the rider or endorsement letter excluding coverage for 4**
- **Attach a copy of the declination letter for 5**

3.  Yes  No Have you been diagnosed with one of the following pre-qualifying conditions:

**Conditions List**

**Indicate the diagnosed condition(s) below and attach a statement from your physician substantiating the condition(s).**

<p><b>Behavioral Health (Psychiatric)</b></p> <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Bulimia/Anorexia <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Creutzfeldt-Jakob Disease <input type="checkbox"/> Dementia <input type="checkbox"/> Disorders From Organic Brain Syndrome <input type="checkbox"/> Pick's Disease <input type="checkbox"/> Psychotic Disorders <input type="checkbox"/> Wernicke-Kosakoff Syndrome <input type="checkbox"/> Any other behavioral health inpatient treatment within the last 12 months	<p><b>Gastrointestinal</b></p> <input type="checkbox"/> Ascites <input type="checkbox"/> Banti's Disease or Syndrome <input type="checkbox"/> Cirrhosis of the Liver <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Esophageal Varices <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> Ulcerative Colitis	<p><b>Neurologic (continued)</b></p> <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Myotonia <input type="checkbox"/> Palsy <input type="checkbox"/> Paraplegia <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Quadraplegia <input type="checkbox"/> Stroke <input type="checkbox"/> Syringomyelia <input type="checkbox"/> Tay-Sachs Disease
<p><b>Blood/Blood Forming</b></p> <input type="checkbox"/> Aplastic Anemia <input type="checkbox"/> Hemochromatosis <input type="checkbox"/> Hemophilia <input type="checkbox"/> Sickle Cell Disease	<p><b>Infectious</b></p> <input type="checkbox"/> AIDS <input type="checkbox"/> HIV Positive	<p><b>Pulmonary (Lung)</b></p> <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) <input type="checkbox"/> Emphysema
<p><b>Cardiovascular</b></p> <input type="checkbox"/> Angina Pectoris <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Coronary Insufficiency <input type="checkbox"/> Coronary Occlusion <input type="checkbox"/> Pacemaker	<p><b>Musculoskeletal/Connective</b></p> <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Lupus Erythematosus - Systemic <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Scleroderma	<p><b>Other</b></p> <input type="checkbox"/> Kidney Disease requiring Dialysis <input type="checkbox"/> Major Organ Transplant <input type="checkbox"/> Pregnancy <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Physician order for a medically necessary surgical procedure <input type="checkbox"/> Prescription for ongoing maintenance medications, e.g. treatment for blood pressure, high cholesterol, thyroid problems, etc. <input type="checkbox"/> Physician order for ongoing therapies to treat a medical condition, such as physical therapy, occupational therapy, speech therapy, cardiac rehabilitation therapy
<p><b>Endocrine (Hormonal)</b></p> <input type="checkbox"/> Addison's Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Diabetes (Type I or II) <input type="checkbox"/> Porphyria <input type="checkbox"/> Wilson's Disease	<p><b>Neoplasm (Cancers)</b></p> <input type="checkbox"/> Cancer (except skin cancer) treated or diagnosed within the past 5 years <input type="checkbox"/> Melanoma <input type="checkbox"/> Hodgkin's Disease <input type="checkbox"/> Leukemia <input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> Non-Hodgkin's Lymphoma <input type="checkbox"/> Wilm's Tumor	
	<p><b>Neurologic</b></p> <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease) <input type="checkbox"/> Friederich's Ataxia <input type="checkbox"/> Guillain Barre Syndrome <input type="checkbox"/> Huntington's Chorea	

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. **(Please attach a copy of the Declination letter.)**

**In order to qualify for the NHHP-FED 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 NHHP-FED.
- (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 NHHP-FED premium going to be paid by your employer or family member(s) employer or is your employer reimbursing you for any portion of your NHHP-FED premium?  Yes  No

**Coverage Effective Date – If accepted for this coverage, your effective date may be no earlier than the first of the month following the date we receive your complete application and required premium.**

Premium Payment Method:	<input type="checkbox"/> Monthly invoice – Administrative fee of \$10.00 per month will be added to the monthly premium.
	<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 worksheet to help calculate the correct monthly premium.**

Premium Calculation Worksheet: (Use the attached rate sheet for plan option and rate by age.)	Amount
Non-Tobacco Premium	\$
Tobacco Premium	\$
Additional administrative fee for monthly Invoicing (add \$10.00 )	\$
<b>Total amount of monthly premium due</b>	<b>\$</b>

**A check made payable to NHHP-FED for the first month’s premium is submitted with this application. If you selected to pay premium via monthly 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 NHHP-FED immediately upon the change in any of the information contained in the application. I understand I must notify you immediately if there is a change in my employment or that of my family members. 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.

NHHP-FED is a temporary federally funded program and is scheduled to terminate on 12/31/2013 or earlier in the event funding is no longer available, or if the contract with the federal government is canceled or not renewed. The State of New Hampshire and New Hampshire Health Plan are not in any way responsible for funding the payment of claims or any other costs of the program. The applicant understands that the design, implementation, operation, and administration of the NHHP-FED program, including the denial of participation or eligibility in NHHP-FED and the denial or nonpayment of a claim, is governed by federal rules and requirements and a contract with the federal government, and agrees not to sue New Hampshire Health Plan or the State of New Hampshire or their representatives for any such actions.

**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 NHHP-FED (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.**



**NHHP-FED**  
**Residency Affidavit**

1. Under penalty of perjury, I declare that I am a resident of the state of New Hampshire as defined in paragraph (3) below. I understand that if I falsely claim to be a resident of the state of New Hampshire, I am subject to prosecution under applicable laws (the penalties for a false claim may include criminal charges and/or fines) and the denial of any claim under the health benefit plan for which I am applying.
2. I also understand that this statement will be relied upon in connection with continuation of coverage and future renewals of the health benefit plan for which I am applying and the payment of claims, and that it is my responsibility to inform NHHP-FED when I cease to be a New Hampshire resident and that I will be subject to the penalties listed above if I fail to do so.
3. A resident is a person who maintains his or her true, fixed and permanent residence within the state of New Hampshire, does not claim a residence in any other state for any purpose and who has, through all of his or her actions, demonstrated a current intent to designate that the permanent residence is his or her principal place of physical presence for the indefinite future to the exclusion of all others.
4. My permanent residence referred to above is located at

\_\_\_\_\_ *street address (not P.O. Box)*

\_\_\_\_\_, New Hampshire \_\_\_\_\_  
*city or town* *zip*

Length of time at present address: \_\_\_\_\_

5. I understand that I may be asked to file an updated affidavit with NHHP-FED from time to time and other confirmatory proof of residence (e.g., rent receipts, mortgage payments, and utility bills). I will cooperate when asked to do so.

I, the applicant, have read the above and understand the penalties that may apply if I falsely claim to be a New Hampshire resident.

Date: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

**For applicants under the age of 18:** I am the  custodial parent /  legal guardian of the applicant. Under penalties of perjury, I declare that the above statements of or on behalf of the applicant are true.

Date: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

My residence is: \_\_\_\_\_  
*street address (not P.O. Box)*

\_\_\_\_\_, \_\_\_\_\_  
*city or town* *state* *zip*

My telephone: home/cell: \_\_\_\_\_ work: \_\_\_\_\_  
*area code & number* *area code & number*



**NHHP-FED**

**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: \_\_\_\_\_

**For applicants under the age of 18:** I am the  custodial parent /  legal guardian of the applicant. Under penalties of perjury, I declare that the above statements of or on behalf of the applicant are true.

Date: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_