



South Dakota Risk Pool

APPLICATION FOR SOUTH DAKOTA RISK POOL HEALTH COVERAGE

Please mail the completed application, all necessary documentation, and applicable premium to:

South Dakota Risk Pool
c/o Bureau of Personnel
500 East Capitol Avenue
Pierre SD, 57501

or fax to:

South Dakota Risk Pool
605.773.6840

For questions call: 605.773.3148 and ask for a Risk Pool representative.

Failure to completely answer all questions and to submit required documentation may delay the processing of your application.

1. Applicant Information

| | | | | | | |
|---|-------------------------|---|--|------------------|-------------------|--|
| Last Name of Applicant | | First Name of Applicant | | Middle Initial | Social Security # | |
| Age | Date of Birth(mm/dd/yy) | Sex (check one) Male <input type="checkbox"/> Female <input type="checkbox"/> | Email Address | | | |
| Mailing Address | | | Physical Address (if different from mailing address) | | | |
| City | State | Zip | City | State | Zip | |
| Home Telephone # | | Cell phone # | | Work Telephone # | | |
| Name and Social Security Number of Parent or Legal Guardian if applicant is a minor | | | | | | |

2. Reason for Application

Review the eligibility options below and **choose ONLY one** (A, B, or C).

A. Loss of Coverage - Adults and Children

Check the **one (1) reason** that best describes why you are applying for coverage.

- Coverage is no longer available because I moved from the service area
- Insurance carrier is not renewing coverage in South Dakota
- Insurance carrier is not renewing employer group coverage because the group no longer meets eligibility requirements
- Employer is no longer providing group insurance
- COBRA or South Dakota Continuation expired
- No longer eligible for employer group coverage and COBRA or South Dakota Continuation coverage not available
- No longer eligible for Medicaid
- Other (please specify) _____

- Complete with most recent carrier information:

Name of insurance carrier or program: _____

Coverage or program effective date: _____

Coverage or program termination date: _____

Name of policy holder: _____

- **Required documents to be submitted with application:** Letter showing most recent 12 months of coverage, letter of coverage termination, and proof of South Dakota residency.

B. Uninsurable Child (under age 19)

Check all that apply. If all are not checked you may not be eligible.

- I am a citizen of the United States.
- I have been declined health coverage, from two major insurance carriers in the last six (6) months.
- I have not had major medical coverage or creditable coverage within the last six (6) months.

- **Required documents to be submitted with application:** birth certificate, proof of South Dakota residency, and rejection letters from two (2) insurance companies.
- **All children enrolled in the risk pool under this eligibility criteria may be subject to a six months preexisting condition waiting period.**

C. Lifetime Maximum Benefit (LTM) – Adults and Children

- I have or will soon exhaust my lifetime maximum benefits under my current health policy.

- Complete with most recent carrier information:

Name of insurance carrier or program: _____

Coverage or program effective date: _____

Coverage or program termination date: _____

Name of policy holder: _____

- **Required documents to be submitted with application:** Letter showing most recent 12 months of coverage, letter of notice you are nearing your lifetime maximum benefit, and proof of South Dakota residency.

3. Plan Options: (The plan year runs from July 1st through June 30th.)

Changes to your deductible will only be effective at the beginning of the plan year (July 1). **You may not decrease deductible amounts after your initial selection.** Coverage is not effective until notice is received from the Plan Administrator and the actual effective date may vary from the requested effective date.

- \$1,000 deductible- *Plan A*
- \$3,000 deductible- *Plan B*
- \$3,000 deductible with Health Saving Account (HSA) qualifying option- *Plan B*
- \$10,000 deductible- *Plan C*

Requested effective date for coverage ____/____/____

4. Tobacco User Declaration

I have used tobacco products (includes all tobacco products) during the 12 months immediately preceding the date of this application.

- Yes
- No

Failure to accurately disclose tobacco use is cause for non-renewal or at the option of the Plan, to allow continued coverage with the enrollee being responsible for paying the appropriate premiums including those due retroactively. Once an enrollee has been tobacco free for 12 consecutive months, they may contact the Risk Pool Administrator in writing to request a change of premium rates to a 'non-tobacco' user status. The Plan reserves the right to verify an enrollee's claim regarding tobacco use through medical means at the expense of the plan.

5. Other Insurance

Are you currently eligible for other major medical coverage including but not limited to group health coverage, Medicare, Medicaid, or Children's Health Insurance Program (CHIP)?

- Yes
- No

Health benefits can be provided by other insurance policies, coverage, or programs that pay benefits when a certain diagnosis is made, a certain dollar threshold has been met, a certain procedure is performed, or certain charges are incurred. Examples include cancer policies, hospital indemnity policies, supplemental insurance (AFLAC type policies), and others.

6. Agreement and Authorization

I have read, or had read to me, the completed application. I certify I am legally authorized to apply for coverage for myself or my child or for child for whom I have legal guardianship. I also hereby agree (1) I represent all information shown above is correct, and having read this form and the above statements, answers, and any attachments, I represent they are true and complete to the best of my knowledge and belief, and agree this application (and any other required parts) shall be the basis for any plan provided; (2) if I made any false statements or misrepresentation, or have failed to disclose or have concealed any material fact, coverage provided under this application may be considered void and the allowance of benefits will be refused; (3) I understand I must pay the appropriate premium amount in advance to maintain coverage and have included a signed automatic bank draft form and premium for the first two months of coverage; and (4) I must notify the Risk Pool of any changes which would affect my eligibility in the program. If this application is denied, the only obligation of the Risk Pool will be to return any premium paid.

I authorize any health care provider to release medical records to the Risk Pool or its designee when reasonably related to the coverage for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization. I authorize any insurance carrier to release records pertinent to prior health or medical coverage provided under that plan, including limited benefit plans. I further agree upon request to furnish all information required to administer this coverage.

Applicant's Signature _____ Date ___/___/___

If applicant is a minor,
Signature of parent or legal guardian _____ Date ___/___/___

For agent use only (If applicable):

Notice to Agents: Risk Pool commissions will be paid and sent according to the information provided on the application. You must choose to have commissions payable to an agent license number or a business FEIN. Please be sure to complete this section of the application completely.

Check one

- Pay SD Agent license**
- Pay Business FEIN #**

| | | | | |
|---|-------|----------|---------------------------------|--|
| Agent SD License Number | | | Business FEIN # (if applicable) | |
| Agent Name (printed) | | | Agent Social Security # | |
| Business or Agency Name (if applicable) | | | Email Address | |
| Mailing Address | | | Telephone Number | |
| City | State | Zip Code | Fax Number | |
| Agent Signature | | | Date | |