



PO Box 1090
Great Bend, KS 67530
Fax: (620) 793-1199
www.wship.org

Questions? Call 1-800-877-5187

Enrollment Information

(Medicare-Eligible Basic Plan)

Important – Please Read!

Please review this information carefully and **return your completed application, along with a copy of all required documents and your applicable premium payment to the address above.** (You may fax your application, provided the original and premium payment are sent by mail within 5 days.)

Applicants are encouraged to use a licensed insurance agent. If you do not have an agent, use the **WSHIP Agent Directory** to locate an agent who is knowledgeable about the WSHIP application process. Call Customer Service at 1-800-877-5187 to request a copy, or go to www.wship.org.

About WSHIP

The Washington State Health Insurance Pool (WSHIP) is an independent, non-profit health plan created by the Washington State Legislature. We offer individual health insurance coverage to state residents rejected for coverage by health carriers due to medical reasons. Our benefit plans, premiums, eligibility rules, and other program requirements are governed by state law. A Board of Directors with representatives for consumers, employers, insurance agents, health carriers, health care providers, and the Insurance Commissioner oversee the organization. WSHIP is administered by Benefit Management Inc. (BMI), working with Medco for pharmacy services, First Choice Health for provider network services, and Qualis Health for care coordination and disease management programs.

Eligibility

To be eligible for WSHIP's Basic Plan you must meet all of the following requirements:

- You must be a resident of Washington state;
- You must be enrolled in Medicare Part A and Part B;
- You must provide evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a pre-existing conditions limitation on a Medicare supplemental insurance policy, or not have comprehensive Medicare supplement coverage available to you; and
- You must not have access to a reasonable choice of Medicare Advantage Plans (Part C). (See enclosed details for how "reasonable choice" is defined.)

Your dependent children may be covered by WSHIP provided that you are eligible for and are enrolled in WSHIP. Coverage for dependent children is available under a separate policy. Your dependents are not required to have been rejected due to their score on the Standard Health Questionnaire. Dependent children must be unmarried and under the age of 19. Coverage can be extended for dependent children age 19 and older who are disabled. If your dependents are not Medicare-eligible, please contact WSHIP for a different form to enroll non-Medicare eligible dependent children.

Questions? Contact Customer Service at **1-800-877-5187** or go to www.wship.org.

Instructions

1. Review the benefit plan information carefully.
2. Review the premium rate chart to determine your monthly premium.
3. Fill out the WSHIP application completely.
4. Sign and date your application and attach copies of all required documents.
5. Enclose a check for your applicable premium and mail your application and supporting documents to us in the enclosed return envelope. (You may fax your application if originals and payment are sent by mail within 5 days.)

HOW TO CONTACT US

Call Customer Service at 1-800-877-5187

(8 AM to 5 PM Pacific Time, Monday – Friday)

Visit our website at www.wship.org

Write to us at: PO Box 1090, Great Bend KS 67530

Benefit Plan & Premiums

Benefit Plan

WSHIP's Basic Plan supplements your existing Medicare Parts A and B benefits, as well as providing additional benefits for some services not covered by Medicare. The plan includes coverage for preventive care and other medical services; it also includes annual out-of-pocket expense limits.

This plan does not provide prescription drug coverage except supplemental benefits for medications covered under Medicare Part B.

WSHIP pays as **secondary insurance** and covers your patient responsibility for Medicare-eligible expenses (the amount you owe after Medicare pays your provider). If the service is not covered by Medicare but is covered by WSHIP, you pay a 20% coinsurance up to the annual out-of-pocket expense limit.

A Benefit Plan Summary is included in this packet. A complete policy is available on our website at www.wship.org; or you may request a copy from Customer Service.

Premiums

Monthly premium rates are included in this packet. Premiums are based on your age. State law requires WSHIP premiums to be 110%-150% of the average of what the largest carriers in the state charge for their individual plans with benefits similar to WSHIP. Premiums cover about one third of the cost of providing coverage; health carriers pay the remaining costs. (WSHIP is not state-funded.)

How to Determine if You Have Reasonable Choice of Medicare Advantage Plans

Under Washington law effective August 1, 2009, to be eligible for coverage under WSHIP's Medicare-eligible Basic Plan you must live in a Washington county where *you do not have reasonable choice* of comprehensive Medicare Advantage Plans (Part C).

Definition of Reasonable Choice

Reasonable choice of Medicare Advantage Plans means:

1. You have a choice of health maintenance organization (HMO) or preferred provider organization (PPO) Medicare Advantage Plans offered by at least three different carriers that have had provider networks in your county of residence for at least five years.
2. The benefit plan options include coverage at least as comprehensive as Plan F Medicare supplement plan combined with Medicare Parts A and B.
3. The benefit plan options also provide access to adequate and stable provider networks that make up-to-date provider directories easily accessible on the carrier website, and will provide a hard copy, if requested.
4. The health care provider with whom you have an established care relationship and from whom you have received treatment within the past twelve months is not a member of the available HMO or PPO Medicare Advantage Plan carrier networks.

Counties with Reasonable Choice

The Washington counties below have been determined by WSHIP to have reasonable choice of Medicare Advantage Plans. *If you live in one of these counties you are not eligible for WSHIP unless your health care provider is not included as a member of at least one of the HMO or PPO benefit plans available to you.*

Counties with reasonable choice of Medicare Advantage Plans in 2011:

**Clark, Island, King, Kitsap, Pierce, Skagit, Snohomish, Spokane, Thurston,
and Yakima**

Questions?

If you have any questions about this eligibility requirement, there are several resources available to assist you:

- You can locate an agent in your area on WSHIP's website www.wship.org
- You can contact the Statewide Health Benefits Advisors "SHIBA" at 1-800-562-6900 or SHIBAhelpLine@oic.wa.gov
- Visit the website of the Office of the Insurance Commissioner www.oic.wa.gov
- Contact WSHIP Customer Service at 1-800-877-5187



WASHINGTON STATE HEALTH
INSURANCE POOL

Summary of Benefits

Basic Plan (Medicare)

This plan is for qualified individuals enrolled in Medicare Part A and Part B. It pays as secondary insurance and covers patient responsibility for Medicare-eligible expenses.

This plan does not provide prescription drug coverage except supplemental benefits for drugs covered under Medicare Part B.

WSHIP covers 100% of your Medicare deductible and coinsurance on Medicare-eligible expenses

MEDICAL BENEFITS	
ANNUAL DEDUCTIBLE per individual PCY (1)	None
COINSURANCE (amount you pay after deductible)	0% for Services covered by Medicare 20% for Covered Services <u>not</u> covered by Medicare
OUT-OF-POCKET LIMIT PCY (The maximum amount you pay yearly including deductible and coinsurance.)	per Individual \$850 per Family \$1,700
LIFETIME MAXIMUM BENEFIT	\$2,000,000

COVERED SERVICES	COVERAGE LIMITATIONS	YOU PAY if <u>not</u> covered by Medicare
PREVENTIVE CARE (deductible waived)		
Preventive care exams and immunizations	\$500 PCY	0%
PROFESSIONAL SERVICES		
Office, inpatient, and outpatient professional services		20%
DIAGNOSTIC SERVICES		
Diagnostic x-ray & laboratory services		20%
Mammography (deductible waived)		0%
HOSPITAL SERVICES		
Inpatient (2) and outpatient facility services		20%
EMERGENCY CARE		
Emergency room		20%
OTHER SERVICES		
Acupuncture	12 visits PCY	20%
Ambulance		20%
Chemical Dependency	30 Inpatient days PCY 28 Outpatient visits PCY	20%
Diabetes Education (certified only; deductible waived)		0%
Home Health Care (2)	130 visits PCY	20%
Hospice and Respite Care	Hospice: not limited Respite: \$7,500 PCY	20%
Massage Therapy (when prescribed by a physician)	12 visits PCY	20%
Maternity Services		20%
Medical Supplies and Equipment (3)		20%
Mental Health Services (2)		20%
Oral Surgery		20%
Physical, Speech, Occupational, and Respiratory Therapies (2)		20%
Skilled Nursing Facility (2)	100 days PCY	20%
Spinal Manipulations		20%
Tobacco Cessation (WSHIP's designated provider only)	one participation PCY	0% - WSHIP program
Temporomandibular Joint (TMJ) Disorders	\$1,000 lifetime maximum	20%
Transplant Surgery (3)	\$350,000 lifetime maximum	20%
PRESCRIPTION DRUGS are NOT COVERED except for drugs covered under Medicare Part B.		

NOTES: (1) PCY = Per Calendar Year
(2) A prior review for Medical Necessity is recommended if service is not covered by Medicare
(3) Pre-approval is required

PRESCRIPTION DRUGS

WSHIP's Medicare Basic Plan does not provide coverage for prescription drugs (except for drugs covered under Medicare Part B). Prescription drug services are administered by Medco; 1-800-859-8810.

LIMITED COVERED SERVICES

- Preventive Care
- Acupuncture
- Chemical Dependency
- Home Health Care and Respite Care
- Massage Therapy
- Skilled Nursing Facility
- Tobacco Cessation
- Temporomandibular Joint (TMJ) Disorders
- Transplant Surgery

EXCLUSIONS TO COVERED SERVICES

Benefits are not provided for treatment, surgery, services, drugs or supplies for any of the following:

- Cosmetic and Reconstructive Services (with some exceptions)
- Counseling, Educational or Training Services (except Diabetes Education)
- Custodial Care
- Dental Care
- Fertility or Infertility; and Sterilization Reversal
- Foot Care (routine care)
- Governmental Medical Facilities
- Investigational or Experimental Services
- Military and War Related Conditions; and Illegal Acts
- Not Medically Necessary Care
- Obesity and Weight Control
- Prescription Drugs (except for drugs covered under Medicare Part B)
- Services For Which You Do Not Have to Pay
- Sex or Gender Reassignment
- Sexual Dysfunction
- Transportation or Travel
- Vision and Hearing Services
- Work-Related Conditions
- Services or supplies not specifically listed as covered in the Plan Policy

ELIGIBILITY

To be eligible for WSHIP's Basic Plan you must meet all of the following requirements:

- You must be a resident of Washington state;
- You must be enrolled in Medicare Part A and Part B;
- You must have been rejected for coverage by a health carrier, offered substantially reduced coverage on a Medicare supplemental insurance policy, or not have comprehensive Medicare supplement coverage available to you; and
- You must not have access to a reasonable choice of Medicare Advantage Plans (Part C).

PRE-EXISTING CONDITIONS

All plans contain a 6-month waiting period for pre-existing conditions; the waiting period may be credited or waived based on your prior health care coverage, subject to approval by WSHIP.

HOW TO CONTACT US

Customer Service: 1-800-877-5187


Mail: PO Box 1090, Great Bend KS 67530

www.wship.org

NOTE: This information is not a contract, nor does it cover all exclusions or limitations. Once you enroll, you will receive a copy of your Plan Policy which will outline your coverage in detail. For a sample copy of the Plan Policy, contact Customer Service or go to www.wship.org.

**Washington State Health Insurance Pool (WSHIP)
2011 Monthly Premium Rates**

MEDICARE BASIC PLAN

		Age	Basic Plan	Basic Plan Low Income ¹	
Income Level 			Regular Rates ----- Table B1	251% - 300% of FPL ² ----- Table B2	250% or Less of FPL ² ----- Table B3
Full Premium	0-34	\$227	N/A	N/A	
	35-44	\$247			
	45-54	\$257			
	55-59	\$285			
	60-64	\$285			
	65+	\$243			\$206
You were enrolled in a prior medical benefit plan during the 63-day period prior to application to WSHIP with continuous enrollment for 18 months.	0-34	\$227	N/A	N/A	
	35-44	\$247			
	45-54	\$257			
	55-59	\$285			
	60-64	\$285			
	65+	\$202			\$178
You have been enrolled in WSHIP continuously for 36 months or more.	0-34	\$227	N/A	N/A	
	35-44	\$247			
	45-54	\$257			
	55-59	\$285			
	60-64	\$285			
	65+	\$231			\$196
You have been enrolled in WSHIP for 36 months or more <u>AND</u> had 18 months of continuous enrollment in a prior medical benefit plan.	0-34	\$227	N/A	N/A	
	35-44	\$247			
	45-54	\$257			
	55-59	\$285			
	60-64	\$285			
	65+	\$192			\$178

¹ You must complete a Low Income Application and receive approval prior to being eligible for Low Income Rates. If you are approved for a Low Income Discount, you will be notified of your adjusted premium rate.

² FPL = Federal Poverty Level

The regular rate is the lowest allowable by law if N/A appears in the Low Income Rate Table for your age. Please do not complete a Low Income Application.

Information and premium rates contained herein are subject to change with a 30-day advance notification.

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Frequently Asked Questions

When will my coverage be effective?

If your completed application is faxed or postmarked on or before the last day of the month, WSHIP coverage will be effective the 1st of the next month. Some exceptions may apply.

Is there a waiting period for coverage of pre-existing conditions?

Yes, there is a 6-month waiting period. In certain circumstances, we will waive or credit this waiting period based on your current or prior creditable coverage.

May I be turned down for coverage?

No, as long as you meet all of the eligibility requirements.

May I keep my WSHIP coverage if I receive assistance from Medicaid?

No. Some exceptions may apply depending upon the type of DSHS medical assistance you receive.

What will happen if I move?

If you move to another location within Washington, you are still eligible for WSHIP. You need to send us a change of address to ensure that you receive important notices about your policy including our required yearly Eligibility Verification Form. If you move out of the state of Washington, you must notify us immediately; you will no longer be eligible for WSHIP and your coverage will terminate.

When does the policy end?

The policy terminates:

- When you send us written notice requesting termination
- For nonpayment of your premium within the 31-day grace period
- When you are no longer a resident of Washington state
- When you become eligible for Medical Assistance (except under certain circumstances)
- When you are no longer enrolled in both Parts A and B of Medicare
- When you reach your \$2 million dollar lifetime benefit maximum
- When you fail to respond to our inquiry about your eligibility or place of residence
- When you commit a material fraud upon or against WSHIP

How are premiums determined?

By law, WSHIP premiums must be based on an average of what the largest carriers in the state charge for their individual plans with benefits similar to WSHIP (not on the use of your health care services).

Are there any discounts available?

Yes, premium discounts are available (if the discount does not result in a premium less than 110% of the standard risk rate) if:

- 1) you have been enrolled in a prior medical benefit plan during the 63 day period prior to application with continuous enrollment for 18 months in the medical plan;
- 2) you have been enrolled in WSHIP for more than 36 months; or
- 3) you have been enrolled in WSHIP for more than 36 months and had 18 months of continuous enrollment in a prior medical plan.

A low income discount is also available for those who are age 65 or older if your gross family income less than 301% of the Federal Poverty Level (FPL) Guidelines and the discount does not result in a premium less than 110% of the standard risk rate. You must submit a Low Income Application and be approved. Please contact Customer Service for an application if you are age 65 or older and think you may qualify for this discount.

What is the process and who determines if I qualify for the low income discount?

WSHIP will send the Low Income Discount Application to you or you may download and print it from our website. We will contact you if additional information is needed. The Low Income Discount Application is then processed by, and eligibility for the discount is determined by, the Washington State Health Care Authority. WSHIP will notify you of their determination.

Should I contact Health Care Authority about my Low Income Discount Application?

No, all communication regarding your application should be directed to WSHIP.

What are my payment options?

You may choose to be billed quarterly, semi-annually or annually and submit payment to WSHIP, or you can choose to have automatic bank withdrawals made monthly. You will indicate your payment option on the application. Please be sure to enclose the amount of premium that is applicable to the payment frequency you selected. For example, if you selected quarterly, multiply the monthly rate by three months and enclose that amount with your application.

How do I change my payment option selection?

Request it in writing. If received by the 20th of the month, it will become effective the 1st of the following month. If you are changing to automatic withdrawal from your bank account, you will need to send us a Bank Service Plan Authorization Form and a voided check or bank MICR form.

What will happen if I do not return my yearly Eligibility Verification Form?

WSHIP must verify your eligibility for coverage on an ongoing basis. An Eligibility Verification Form will be sent to you at least yearly and must be returned to us by the date requested or your policy will be terminated. Please keep an eye out for this important form and return it promptly to avoid losing your coverage. (You must also notify us of addresses changes.)

Can I re-enroll in WSHIP after termination?

If you fail to pay the premium or you voluntarily leave WSHIP, you will not be eligible to reapply until 12 months after termination date. (You can re-apply without meeting the 12 month criteria if you terminated due to having employment-related coverage which was subsequently lost.)

II. INTERNAL APPEAL PROCESS

A. Appeal to WSHIP's Administrator (First Level)

1. The person, or his or her authorized representative, must notify WSHIP's administrator of his or her request for appeal within 90 days of the event giving rise to the appeal. If the complaint concerns a carrier's application of the SHQ scoring tool, the person should include his or her completed SHQ and the carrier's scoring, if available. We have delegated the administrator's responsibility for first level appeals related to pharmacy benefit coverage issues to our Pharmacy Benefit Manager.
2. Within five business days, the WSHIP administrator will respond to the person in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint and the resolution requested.
3. WSHIP's administrator will investigate the complaint, considering all information submitted by the person, and make its decision within 30 days of receipt of the complete information needed to respond to the appeal.
4. WSHIP's administrator will notify the person of its decision in writing and inform the person of any further appeal options. The written notice will explain the decision and any supporting coverage or clinical reasons and will specifically refer to any supporting documents. If WSHIP's administrator fails to make its decision within 30 days of its receipt of the complete information needed to respond to the appeal, such failure is deemed to be an adverse decision and the person may appeal to the next level.
5. If the complaint concerns the carrier's application of the SHQ scoring tool or the timing of the notice of rejection and WSHIP's administrator determines that the carrier erred, WSHIP's administrator will also forward its written decision to the carrier and recommend that the carrier take appropriate action.
6. If a complaint involves denial of coverage of a service, and the person provides written notice to WSHIP's administrator of a need for a speedy appeal process because the regular appeals process timelines could seriously jeopardize the person's life, health or ability to regain maximum function, WSHIP's administrator will provide its written decision within 72 hours of receipt of the appeal request.

B. Appeal to WSHIP's Grievance Committee (Second Level)

1. The person, or his or her authorized representative, must notify WSHIP's administrator of his or her request for appeal to WSHIP's grievance committee within 90 days of an adverse decision by WSHIP's administrator and include a written description of the complaint.
2. Within five business days, WSHIP's administrator will respond to the person in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint and the resolution requested. Within two business days of sending this notice, WSHIP's administrator will forward the appeal, with all relevant information from its files, to the WSHIP's grievance committee.
3. WSHIP's grievance committee will investigate the complaint, considering all information submitted by the person, and make its decision within 30 days of its receipt of the complete information needed to respond to the appeal. The grievance committee may engage independent medical and legal experts to assist in the review process.
4. WSHIP's grievance committee will notify the person of its decision in writing and inform the person of any further appeal options. The written notice will explain the decision and any supporting coverage or clinical reasons and will specifically refer to any supporting documents. If WSHIP's grievance committee fails to make its decision within 30 days of its receipt of the complete information needed to respond to the appeal, such failure is deemed to be an adverse decision and the person may appeal to the next level (if applicable).

5. If the complaint concerns the carrier's application of the SHQ scoring tool or the timing of the notice of rejection and WSHIP's grievance committee determines that the carrier erred, the grievance committee will also forward its written decision to the carrier and recommend that the carrier take appropriate action.
6. If a complaint involves denial of coverage of a service, and the person provides written notice to WSHIP's administrator of a need for a speedy appeal process because the regular appeals process timelines could seriously jeopardize the person's life, health, or ability to regain maximum function, WSHIP's grievance committee will provide its written decision within 72 hours of its receipt of the appeal request.

III. EXTERNAL APPEAL PROCESS (Third Level)

- A. If WSHIP's grievance committee affirms a decision to deny, modify, reduce, or terminate coverage of or payment for health services, the person may appeal the decision to an IRO by notifying the WSHIP administrator within 30 days of receipt of the grievance committee's written decision.
- B. The administrator will gather all relevant documents and deliver them to the IRO within three business days of receiving the person's request for appeal.
- C. The IRO, made up of persons not associated with WSHIP, will review the complaint and make a decision. The IRO will provide its decision in writing to the person and WSHIP within 20 days of the person's request for appeal. WSHIP will pay the charges for the IRO's review and written report.

IV. ENROLLMENT AND SERVICES DURING APPEAL PROCESS

- A. A person denied enrollment by a carrier based on his or her SHQ results may apply for coverage under WSHIP while a review is in progress.
- B. If the complaint is from a WSHIP enrollee contesting a coverage decision and such decision was based on a finding of no medical necessity, WSHIP will continue to provide the service until the appeal is completed. Upon completion of the appeal process, if WSHIP continued to provide the service in question and it is determined that the coverage was properly denied, WSHIP may charge the enrollee for the cost of the services provided.

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Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Please review this notice carefully.

The privacy of your personal health and financial information is very important to us.

I. OUR COMMITMENT TO PRIVACY

Washington State Health Insurance Pool (WSHIP) is required by law to maintain the privacy of your personal health and financial information (PHI) and to provide you with notice of its legal duties and privacy practices with respect to your PHI.

In the course of administering your health benefits, WSHIP collects personal health and financial information from you and your health care providers. These records are used and maintained by WSHIP, but the PHI contained in the records belongs to you.

II. HOW DO WE PROTECT YOUR INFORMATION?

We maintain physical and electronic security safeguards to protect your personal health and financial information (PHI) against unauthorized access. We have policies and procedures in place to make certain we only share the minimum amount of PHI necessary and only with those parties who have a legitimate business need for the information. We have a privacy director who develops procedures to protect your PHI, educates our staff, and tests and enforces our privacy protection mechanisms.

We will not disclose PHI except as permitted by law.

III. TO WHOM IS YOUR PHI DISCLOSED & WHY?

To effectively administer your health benefits, WSHIP must share some of your personal health and financial information (PHI). The law permits WSHIP to use or disclose your PHI for the following reasons:

- **For treatment:** WSHIP may disclose your medical information when requested by a doctor, hospital or other provider requiring the information to appropriately treat you.
- **For payment:** WSHIP may use or disclose your PHI to pay or deny your claims for provider services that may or may not be covered by your WSHIP benefits. This may include exchanging eligibility, benefits or prior authorization information with your health care providers or pharmacy benefits carrier or providing information to your other insurance carrier (if applicable).
- **For healthcare operations:** WSHIP may use or disclose your PHI as required to operate the WSHIP program. For example, PHI may be used in determining the cost of your premiums, to collect your premiums, to support grievance or quality review boards, for audit or accreditation programs or for necessary business purposes. WSHIP may disclose your PHI to the WSHIP care management contractor to enable the contractor to contact you to offer care management assistance, and WSHIP may contact you about treatment alternatives and other health benefits and services.
- **To business associates:** WSHIP contracts with qualified third parties (“business associates”) to perform insurance-related functions on our behalf. For example, WSHIP business associates include the WSHIP administrator, pharmacy benefit manager, care management contractor, and network contractor. WSHIP may disclose protected health information with these business associates in order to allow them to perform these functions. They also may collect, use or disclose protected health information on our behalf. We are

required to have contracts with our business associates that require them to provide the same privacy protections that we provided for your PHI.

- **For the creation of data:** WSHIP may use your PHI for the creation of a historical database that is de-identified (not traceable back to you).
- **To you or to your designee upon your authorization:** WSHIP will release your PHI to you or someone who has the legal right to act for you (your personal representative). You retain the right to give us permission, by a written authorization, to use your PHI or release it to whomever you choose for any purpose. If you give us such an authorization, you have the right to cancel it at any time.

WSHIP considers the activities described above necessary for the proper administration of your health plan. There are also other limited circumstances in which WSHIP must release your PHI. These include:

- **As required by law:** WSHIP may use or disclose your PHI when required to do so by law. For example, we will disclose your PHI to the Secretary of the U.S. Department of Health and Human Services (HHS), should HHS choose to ensure we are in compliance with federal law. Additionally, we may disclose your PHI for the purpose of law enforcement, to correctional institutions as allowed by law, or as otherwise required by state laws.
- **For public health purposes:** WSHIP may use or disclose your PHI to avert a serious threat to your health and safety or the health and safety of others such as reporting disease outbreaks to the department of health.
- **For emergency situations and disaster relief purposes:** If you are unavailable to agree to disclosure due to an emergency situation or one of disaster relief, WSHIP may use or disclose your PHI as reasonably indicated for your best interest.
- **For public safety:** WSHIP may disclose your medical information to appropriate authorities if we reasonably believe you to be a victim of abuse, neglect, domestic violence or other crimes.
- **For judicial and administrative proceedings:** WSHIP may disclose your PHI in the course of any administrative or judicial proceeding. Examples of this include: in response to a court order, subpoena or summons.
- **For health oversight activities:** WSHIP may disclose your PHI to a health oversight agency for activities authorized by law, including investigation of activities involving fraud and abuse, audits, inspections or licensure.
- **For research:** WSHIP may use or disclosure your PHI for limited research purposes as approved by the WSHIP Board.
- **For military and national security:** WSHIP may disclose PHI of enrollees who are armed forces personnel for activities deemed necessary by military command authorities. Furthermore, we may disclose to authorized federal officials, that PHI required for national security activities authorized by the national Security Act (50 U.S. C. 401, *et seq.*).
- **For change of ownership:** WSHIP may use or disclose your PHI to facilitate the change over or acquisition of WSHIP by another insurer.

IV. WHAT ARE MY INDIVIDUAL RIGHTS?

By law, WSHIP must have your written permission (an “authorization”) to use or give out your PHI for any reason that is not described in this Privacy Notice. If you give us an authorization, you have the right to revoke (or cancel) it at any time. Revoking or changing an authorization must be done in writing and shall not affect any uses or disclosures of PHI already performed while the authorization was in effect.

In addition to the right to authorize any specific use or disclosure, you also have the following individual rights (listed below):

- **You have the right to request a copy of our current notice of privacy practices.** Under the law, we are required to provide you with a written copy of this Privacy Notice. You may request a copy of our current Privacy Notice at anytime. You may obtain this Privacy Notice on our web site at www.wship.org or you may request this notice in written form by contacting our Customer Service department.

- **You have the right to request a restriction.** If you have paid for a health care item or service out of pocket in full, you may request WSHIP to restrict the disclosure of your PHI if the PHI pertains solely to that health care item or service. WSHIP must agree to limit the disclosure of your PHI if the disclosure is to a health plan for the purposes of carrying out payment or health care operations as described in this notice. WSHIP is not required to agree to limit the disclosure of your PHI if the disclosure is for treatment. For all other health care items and services which you have not paid for out of pocket in full, you may submit a written request that WSHIP place restrictions and limit the use or disclosure of your PHI. WSHIP may not be able to agree to all requested restrictions, but we will review your request and notify you in writing.
- **You have the right to request a copy of or access to your records.** WSHIP must provide you, or your personal representative, with access to your PHI maintained by WSHIP, except for psychotherapy notes and information we compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding. You also have the right to request we provide copies to you or your personal representative. You must make this request in writing. WSHIP will respond to your request within 30 days unless you have agreed upon an alternative time period. If you have requested copies, a fee for materials, staff time and postage will be charged. Should you prefer, WSHIP can prepare a summary report of your PHI for a fee. WSHIP may limit the information that you can inspect or copy if we have reason to believe that it is necessary to protect you or another person from harm. If we limit your right to inspect or copy, you can ask for a review of that decision. To request copies of records, or information regarding any applicable fees, please contact us by using the information at the end of this notice.
- **You have the right to request and obtain an accounting of disclosures.** You have the right to request a list of those third parties who received a disclosure of your PHI from WSHIP within six (6) years of the date of your request. WSHIP will provide you this information within 30 days of receiving your written request. This list will not include any disclosures that were made to you or your personal representative, disclosures you authorized, disclosures made for treatment, payment or health care operations activities as described in this notice, incidental disclosures, disclosures made for law enforcement purposes, disclosures to a correctional institution, disclosures made for national security or intelligence purposes, or disclosures made prior to the mandatory effective date of this requirement: April 14, 2003. This service may be subject to a fee. To request an accounting of disclosures, or information regarding any applicable fees, please contact us by using the information at the end of this notice.
- **You have the right to be notified of a security breach involving your records.** WSHIP is required to notify you in the event that your unsecured PHI is acquired, accessed, used or disclosed. WSHIP must provide you this notification within 60 days after we discover the security breach, unless we are instructed to delay the notification by law enforcement. We may not be required to notify you of unintentional or inadvertent disclosures of your PHI.
- **You have the right to request an amendment.** You have the right to request that WSHIP amend your medical records that you feel are incorrect or incomplete. You must submit your request in writing to the address listed at the end of this notice. This request must include the reason for the requested amendment. WSHIP may accept or deny your request for amendment and will provide you with a written explanation. If WSHIP denies your request, you may respond with a written statement of disagreement and request the statement be appended to the medical record.
- **You have the right to request confidential communications.** If you would like to request that WSHIP communicate with you in confidence, in a different manner or at an alternative location, (for example: you may request that we send materials to a P.O. Box instead of your home address), please submit your request, including the reason for the request, in writing to the address listed at the end of this notice. WSHIP will accommodate all reasonable requests if we are able.
- **You have the right to submit a complaint.** In the event that an accidental or inappropriate disclosure of your PHI occurs, you have the right to expect WSHIP to mitigate or correct any loss or damage you may suffer. If you feel that WSHIP has violated your privacy rights set out in this notice, you or your personal representative may complain directly to WSHIP by using the information at the end of this notice, or to the Secretary of the U.S. Department of Health & Human Services (HHS). A Customer Service Representative will provide you with the address to HHS upon request and assist you in filing your complaint. Filing a complaint with WSHIP or HHS will not affect your benefits or services provided by WSHIP. We shall not retaliate in any way if you choose to file a complaint.

For more information regarding filing a complaint, exercising any of the above-described rights or any questions relating to our Privacy Notice, please contact our privacy director or a Customer Service Representative using the information at the end of this notice.

V. CHANGES TO THIS NOTICE OR THE PRIVACY PRACTICES OF WSHIP

All rights and privacy practices described in this Privacy Notice will take effect on January 1, 2010 and remain in effect until replaced by an updated Privacy Notice. WSHIP is required by law to follow the privacy practices described in this notice for as long as it is in effect.

WSHIP reserves the right to change the way we use or disclose your personal health and financial information (PHI). If WSHIP makes any changes to the privacy practices described in this notice, WSHIP will provide an updated notice via www.wship.org. Upon its effective date, the new notice provisions will be effective for any uses or disclosures by WSHIP.

VI. CONTACT INFORMATION

Address: WSHIP Administrator, Attn: Privacy Director
P.O. Box 1090
Great Bend, KS 67530

Customer Service: If you have any questions regarding this Privacy Notice, please call the toll-free Customer Service number at 1-800-877-5187.



WASHINGTON STATE HEALTH
INSURANCE POOL

Application

Medicare-Eligible Basic Plan
Questions? Call 1-800-877-5187

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 and premium payment are sent by mail within 5 days.) **You must be a resident of Washington state and meet other eligibility criteria to apply.** If you are not eligible for Medicare, do not fill out this application; request our Non-Medicare Plans application.

SECTION 1: AGENT INFORMATION		<i>If you are applying through an Agent, the Agent must provide the information below and sign this section.</i>	
Agent Name		Firm or Agency	
Agent Mailing Address		City	State Zip Code
Agent Phone ()		Agent Email Address	
Agent's Washington State License Number		<input type="checkbox"/> Copy of current license attached* <input type="checkbox"/> Copy of current license on file with WSHIP* * Must be attached or on file to receive agent commission	
Agent's 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 WSHIP	
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(s).			
Agent Signature: X _____		Date Signed: _____	

SECTION 2: APPLICANT INFORMATION				
Last Name		First Name	MI	Social Security Number - -
<input type="checkbox"/> Male <input type="checkbox"/> Female		Birth Date (MM / DD / YYYY) / /	Age	
Street Address (required; must attach proof)		City	State	Zip Code
County of Residence		Home Phone ()	Work Phone or Cell Phone ()	
Email Address		Secondary Contact Person Name*	Secondary Contact Person Phone ()	
Name of Custodial Parent / Guardian if Applicant is a Minor or Not Legally Competent				
(If different from above) Billing Address and Name of Organization Responsible for Payment (if applicable)				
Billing Address		City	State	Zip Code
Organization Paying Premium		Organization Contact Person	Organization Contact Person Phone ()	
Receiving DSHS Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach your DSHS or Healthy Options ID card.				

* Secondary contact is a person who will know how to get in touch with you if we are unable to reach you. This person is not a personal representative unless a Personal Representative Form has been submitted for him/her.

SECTION 3: DEPENDENT INFORMATION *(if more than two, list on separate sheet or copy page)*

If you are eligible for WSHIP and enroll, you can elect to cover your dependent children. They do not have to be rejected by a health carrier. Dependent children must be unmarried, and under age 19 (unless disabled). Dependents must be enrolled in Medicare Part A and Part B to be eligible for the Basic Plan. Do not use this form for dependents that are not eligible for Medicare; contact WSHIP for a form to enroll non-Medicare dependent children in WSHIP.

Additional premiums are required for each dependent.

List dependents to be covered below: (only list dependents you want covered by WSHIP's Basic Plan)

A	Dependent Last Name	First Name	MI	Social Security Number - -
Relationship to Applicant		Birth Date (MM / DD / YYYY) / /	Age	
Disabled and 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, receiving Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Entitlement date: / /		
Receiving DSHS Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach your DSHS or Healthy Options ID card.				

B	Dependent Last Name	First Name	MI	Social Security Number - -
Relationship to Applicant		Birth Date (MM / DD / YYYY) / /	Age	
Disabled and 19 and older? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, receiving Social Security disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Entitlement date: / /		
Receiving DSHS Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach your DSHS or Healthy Options ID card.				

Is Applicant or any Dependent listed above currently insured through WSHIP? Yes No

If yes, name of person(s):

Relationship to Applicant: _____ Policy Number: _____

SECTION 4: OTHER COVERAGE *WSHIP will pay secondary to any other coverage unless preempted by federal law.*

Do you or any person named on this application have any other medical or hospital insurance in addition to Medicare Parts A and B including public programs such as Medicaid? Yes No

If yes, complete the following for each person(s) and attach copy of identification card(s): (if more than one coverage, list on separate sheet or copy page)

Last Name	First Name	MI	Social Security Number - -
Insurer Name	Insurer Phone ()	Policy Number	
Description of Coverage	Effective Date: / /	Termination Date: / /	
Is it a Group Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is it your intent to replace it with this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, remember to cancel your other coverage.)		

SECTION 5: ELIGIBILITY INFORMATION

I certify that I am eligible for coverage because I meet the following **FOUR** requirements:

1 **I AM A RESIDENT OF THE STATE OF WASHINGTON**

“Resident” means a person who is domiciled in Washington state for purposes other than obtaining insurance. Domicile denotes a person’s permanent home and place of habitation. Evidence of residency includes, but is not limited to, one of the documents listed below. WSHIP may request additional proof of residency.

I have included a copy of one of the following documents as proof of residency (proof must match your home street address in Section 2):

Check one box to indicate the document you are including. Do not send original; it will not be returned.

- A bill in your name from any public utility at your dwelling in Washington state (excludes cell phone bills)
- Receipts for rent, mortgage or lease payments for your dwelling in Washington state
- A Washington state driver’s license or state identification card
- Proof of registration and payment in Washington of taxes and fees on motor vehicles
- Proof of employment in Washington state
- A voter registration card
- A federal tax return as a resident of Washington state
- Bank statement (excludes credit card statements)

2 **I AM ENROLLED IN MEDICARE PART A AND PART B**

I have included a copy of my Medicare card. (Also, for dependents to be covered who are Medicare-eligible.)

3 **I MEET ONE OF THE ELIGIBILITY CATEGORIES LISTED BELOW:**

Check one box below for the eligibility category you are applying under:

- I WAS REJECTED FOR MEDICARE SUPPLEMENTAL INSURANCE FOR MEDICAL REASONS**
I received notification of rejection for coverage from a Washington state licensed Medicare supplemental policy issuer. I have included a copy of the issuer’s rejection notice.
- I WAS OFFERED SUBSTANTIALLY REDUCED MEDICARE SUPPLEMENTAL COVERAGE**
I have evidence of (1) a requirement of restrictive riders; (2) an up-rated premium; or (3) a pre-existing conditions limitation. I have included a copy of the issuer’s offer notice.
- COMPREHENSIVE MEDICARE SUPPLEMENT COVERAGE IS NOT AVAILABLE IN MY COUNTY**
- COMPREHENSIVE MEDICARE SUPPLEMENT COVERAGE IS NOT AVAILABLE TO ME BECAUSE I AM UNDER AGE 65**

Note: Additional information may be requested. Also, WSHIP will accept an issuer letter as evidence of WSHIP eligibility for up to 180 days from the date of the letter. Applicants may be required to reapply to the issuer of Medicare supplemental coverage if the letter was received more than 180 days from the WSHIP application date.

4 **I DO NOT HAVE ACCESS TO A REASONABLE CHOICE OF MEDICARE ADVANTAGE PLANS (PART C)**

Medicare Advantage Plans (Part C) combine Part A and B coverage, but are provided by private insurance companies. Part D coverage may also be included.

Check one box below for the eligibility category you are applying under:

- I reside in a Washington state county where I do not have a choice of health maintenance organization or preferred provider organization Medicare Advantage Plans offered by at least three different carriers that have had provider networks in my county for at least five years. (Plan options must include coverage at least as comprehensive as a Plan F Medicare supplement plan combined with Medicare Parts A and B.)
Name of county: _____ (See WSHIP Enrollment Information for list of counties with reasonable choice of Medicare Advantage Plans.)

- I reside in a county with reasonable choice of Medicare Advantage Plans (Part C) as defined above but the health care provider with whom I have an established care relationship and from whom I have received care within the past 12 months is not included in any of these plans.
Name of provider: _____ **Date of last care:** ____/____/____

YOU ARE NOT ELIGIBLE FOR THIS PLAN IF ANY OF THE FOLLOWING APPLY:

- You have terminated coverage in WSHIP within the last 12 months, unless you can show that you had continuous other coverage from the date WSHIP coverage terminated, which has been involuntarily terminated for any reason other than non-payment of premiums.
- WSHIP has paid out two million dollars in benefits on your behalf.
- You are an inmate of a public institution.
- You have coverage under a public program that duplicates WSHIP benefits.
- You do not reside in Washington state (except qualified resident dependent children temporarily living outside of Washington state).
- You are not enrolled in Medicare Parts A and B.
- You have a reasonable choice of Medicare Advantage Plans (Part C).

SECTION 6: PRE-EXISTING CONDITIONS PROVISION

WSHIP plans have a **six-month waiting period** for pre-existing conditions following the policy effective date. In certain circumstances, we will waive or credit this waiting period based on current or prior coverage.

To help us determine if you qualify for a waiver or credit towards the pre-existing condition waiting period, **complete the following and attach a copy of your Certificate of Coverage from your current or prior health carrier.**

If you **do not have** a Certificate of Coverage, you may provide other documentation (such as a letter from the employer, group administrator or prior health carrier), to demonstrate prior coverage beginning and ending dates.

(if more than one coverage, list on separate sheet or copy page)

Name of Health Carrier		Telephone Number of Health Carrier ()
Name of Subscriber (contract holder)		ID Number of Subscriber
Names of all Persons on Prior Coverage		
Date Coverage Began		Date Coverage Ended
Deductible Amount \$	Out-of-Pocket Maximum Per Year \$	<i>(If available, please <u>attach</u> a copy of the Summary of Benefits for this coverage.)</i>
Type of coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> COBRA <input type="checkbox"/> Other _____		
Type of benefits (check all that apply): <input type="checkbox"/> Medical <input type="checkbox"/> Hospital Only <input type="checkbox"/> Accident Only		

REDUCTION OR WAIVER OF PRE-EXISTING WAITING PERIOD

The pre-existing condition waiting period will be waived or credited to the extent you have been covered under a previous medical plan in the following circumstances:

- a) Applicants will receive a pre-existing condition wait credit for time spent in their immediate previous group or non-catastrophic individual plan, if application is made to WSHIP or a health plan carrier within 63 days of termination of that previous plan. (A catastrophic plan means a plan that has a yearly \$1,820 or more deductible and \$3,640 or more out-of-pocket expense limit; or provides benefits for hospital inpatient/outpatient services and excludes or substantially limits outpatient physician services and those services usually provided in an office setting.)
- b) WSHIP will waive the pre-existing condition wait for any person living in a county without individual coverage who is eligible for such waiver under the standards of the Federal Health Insurance Portability Act (18 months "creditable coverage" and application to WSHIP or a member health plan carrier was made within 63 days of termination).

SECTION 7: PAYMENT INFORMATION

Choose one of the premium payment options below:

- MONTHLY BANK DRAFT** 1 month premium due with application
- QUARTERLY** 3 months premiums due with application
- SEMI-ANNUAL** 6 months premiums due with application
- YEARLY** 12 months premiums due with application

You must also fill out the **Bank Service Plan Authorization Form** included in this application and attach a VOIDED check if you select this option.

To determine your premium amount:

1. Use the enclosed **Monthly Premium Rate Chart** to determine your premium payment. If you need assistance, contact Customer Service at 1-800-877-5187.

Please indicate which premium Table you used: Table # _____

2. If you are applying for a low income discount, you must first submit the undiscounted premium with your application. If you are approved, we will notify you and will credit your account. Full premium is required to be paid until a low income discount is approved.
3. **MAKE CHECKS PAYABLE TO WSHIP.** Submit your premium in the amount applicable to the billing frequency you have selected above. The premiums in our rate chart are monthly; if you choose to pay quarterly, semi-annually or yearly, please multiply the monthly premium by three, six or twelve, respectively.

NOTE: Any changes to your method of payment or automatic withdrawal, including bank information or termination of monthly bank draft, **must be submitted in writing by the 20th of the month** in order for the change to be implemented the first of the following month.

LOW INCOME DISCOUNT INFORMATION

NOTE: This discount is currently available only to applicants age 65 and older once approved for coverage with WSHIP.

Applicants may qualify to receive a low income discount if the following applies:

- Gross family income is less than 301% of the Federal Poverty Level (FPL) Guidelines (see income tables at <http://aspe.hhs.gov/poverty/index.shtml> or call Customer Service at 1-800-877-5187 for more information); and
- Washington state has funds available to support discounts; and
- Discount does not result in a premium that is less than 110% of the Standard Risk Rate in Washington state for the same benefits.

- Check box if you think you qualify and would like to receive a Low Income Discount Application.** (WSHIP will send you this application and notify you of the determination; eligibility is determined by the Washington State Health Care Authority, not WSHIP.)

SECTION 8: EFFECTIVE DATE OF COVERAGE

NOTE: The “**Application Received by WSHIP Date**” is the postmark date of the application that you mailed to WSHIP or the date WSHIP receives a faxed copy of your application, whichever occurs first. The original application must be postmarked and mailed to WSHIP no later than five (5) days following the date you faxed the application to WSHIP. Once the application is approved, your insurance coverage and premiums will begin on the first (1st) of the month based on your choice.

Check one choice below to select your effective date of coverage:

AS SOON AS WSHIP CAN PROCESS MY APPLICATION

I understand that if my application is faxed or postmarked on or before the last day of the month, then I may be eligible for WSHIP coverage effective the 1st of the next month. However, if my application is faxed or postmarked after the last day of the month, my coverage will not start until the 1st of the FOLLOWING month.

Example: If received July 31, will be effective August 1; if received August 1, will be effective September 1.

A FUTURE DATE

This must be on the 1st of the month and can be no more than 60 days later than when your application was faxed or postmarked. (Example: If postmarked May 2, your coverage can be effective no later than July 1.)

What Future Date of Coverage do you want? (month) _____ (year) _____

AN EARLIER DATE

To be eligible for an earlier (retroactive) effective date, these two things must be true:

- You applied for individual coverage with a Washington state health carrier no later than the 20th of the month for an effective date of the 1st of the following month, and you were rejected; and,
- You are mailing or faxing this WSHIP application within 15 days of receiving that carriers' Notice of Rejection.

Example: You applied to a health carrier on April 20; you were rejected and received that rejection notice on May 3; you applied to WSHIP on May 15. You may request a WSHIP effective date of May 1.

If both of the above are TRUE, you may select an effective date that your coverage with the individual carrier would have been effective:

Date of the application to the other carrier _____

Requested WSHIP Effective Date: (month) _____ (year) _____

SECTION 9: VOLUNTARY INFORMATION

Completing this section is **voluntary** and will not affect your ability to enroll, but may help us improve our services.

Where did you hear about WSHIP?

- Health carrier (insurance company) sent me materials
 Medical office/hospital/clinic provided WSHIP brochure
 State agency
 Other: _____

Where did you get your WSHIP application?

- Health carrier mailed it to me
 WSHIP website
 Called WSHIP Customer Service
 Other: _____

Are you currently?

- unemployed
 employed
 self-employed
 retired

What is your yearly household income?

- Less than \$18,000
 \$18,000 - \$36,000
 Over \$36,000

of people in household _____

Is English your first language? Yes No

If no, what is?

Do you have Internet access? Yes No

What is your occupation?

WASHINGTON STATE HEALTH INSURANCE POOL

**BANK SERVICE PLAN
AUTHORIZATION FORM**

TO: The financial institution named on the Request for Bank Service Plan – Authorization Form

So that you may comply with your depositor's request, the Washington State Health Insurance Pool (WSHIP) agrees:

- a) To indemnify you and hold you harmless for any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, order or direction to debit an account purporting to be executed by WSHIP and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
- b) In the event that any such check, draft, order or direction shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in forfeiture of insurance.
- c) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your action taken pursuant to the foregoing request or in any manner arising by reason of your participating in the foregoing plan of premium collection.



Washington State Health Insurance Pool • PO Box 1090 • Great Bend, KS 67530



WASHINGTON STATE HEALTH
INSURANCE POOL

REQUEST FOR BANK SERVICE PLAN – AUTHORIZATION FORM (Optional)

For Monthly Premium Payments Only

TO: Washington State Health Insurance Pool

Please use your Bank Service Plan to make my premium payments by withdrawing funds by automatic debit entry from the account below.

WSHIP will withdraw from your account the first Friday of each month except when it falls on the 1st, 2nd, or 3rd. In that case, we will then withdraw on the second Friday of the month. If you have any questions, call WSHIP Customer Service at 1-800-877-5187.

Name as shown on Account Insured / Applicant

Insured / Applicant Identification Number (if you are a NEW Applicant, leave blank)

Name of Financial Institution Branch

City State ZIP

Transit/ABA No. _____ Account No. _____

Please indicate below the type of account to be debited:

Checking

Savings

As a convenience to me, I authorize WSHIP to pay and charge to my account automatic debit entries made upon my account by, and payable to, the order of Washington State Health Insurance Pool. I agree that WSHIP's rights with respect to each such charge will be the same as if it were personally executed by me. **This authorization is to remain in effect until WSHIP receives written notice from me to revoke it.** Any changes to your method of payment or automatic withdrawal, including bank information or termination of monthly bank draft, **must be submitted in writing by the 20th of the month** in order for the change to be implemented the first of the following month.

X _____ / /
Authorized signature as shown on account Date

ATTACH A VOIDED CHECK HERE:

Please return the Bank Service Plan to:

Washington State Health Insurance Pool
PO Box 1090
Great Bend, KS 67530



WASHINGTON STATE HEALTH
INSURANCE POOL

PERSONAL REPRESENTATIVE FORM (Optional)

Include this form with your application if you wish to designate someone as your Personal Representative(s) for discussion and disclosure of Personal Health Information and Personal Financial Information with WSHIP or its health plan administrator(s). This designation will not affect benefits, claims processing and payment, or eligibility status.

Type of Information

WSHIP and its health plan administrator(s) may discuss or release Personal Health Information (PHI) and Personal Financial Information (PFI) to my Personal Representative(s) regarding the following information: eligibility, billing, payment status, benefits, claims, medical information used to make payment decisions, providers, appeals, and complaints about my health insurance coverage through the Washington State Health Insurance Pool (WSHIP), and or its health plan administrator(s).

Authorized Use and/or Disclosure

I authorize WSHIP and or its health plan administrator(s) to release PHI and PFI to the person(s) named as my Personal Representative for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Personal Representative is not a health care provider, or other person subject to federal privacy laws, my PHI and PFI may no longer be protected by those privacy laws and may be subject to re-disclosure by my Personal Representative. WSHIP and or its health plan administrator(s) are not responsible should my Personal Representative further disclose my protected PHI and PFI information. I further understand that I have the right to limit the information that you release under this authorization. Limitations for disclosure are identified below. By leaving this section blank, I am creating no limitation on disclosure of PHI or PFI.

Disclosure Limitations: _____

Expiration and Revocation

The authorization to release information to my Personal Representative(s) will automatically expire 365 days following the termination of my health plan enrollment. I understand that I may revoke this authorization at any time by giving written notice to the Plan administrator. Revocation will not affect any action that WSHIP or its health plan administrator(s) has taken, or any information that has already been released based upon prior authorizations.

Designation of Personal Representative(s)

Name of Authorized Person	Phone Number ()	*Privacy Password
Name of Authorized Person	Phone Number ()	*Privacy Password

**Privacy Password – such as mother’s maiden name, your elementary school, birth city, etc.*

Signature and Authorization

I, the undersigned, do hereby swear that I am the above-mentioned member or an authorized legal representative of the above-mentioned member. I have read and understand the content of this Personal Representative Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

X _____ / /
Signature of Member/Legal Representative Date

Printed Name of Legal Representative

Description of Legal Representative’s
Relationship to Member