



Administered by:
Benefit Management, Inc. (BMI)
P.O. Box 1090
Great Bend, KS 67530
1-800-877-5187
www.wship.org

Non-Medicare Plans Enrollment Packet

Welcome to WSHIP

Enclosed are your Application and enrollment materials from the Washington State Health Insurance Pool (WSHIP). We look forward to assisting you with enrollment in one of our health plans. You are encouraged to use a licensed insurance agent when completing your WSHIP Application; an Agent Directory has been included with this packet for your reference. ***Please review all materials carefully and return your completed Application, along with all required attachments and your 1st month's premium payment, to the address above.***

About WSHIP

The Washington State Health Insurance Pool (WSHIP) is an independent, not-for-profit health plan created by the Washington State Legislature in 1987 to provide access to health insurance coverage for Washington residents and their dependents who are denied individual health insurance. WSHIP coverage is also available to residents of Washington state counties where individual health benefit plans are not offered.

General Eligibility Requirements

- You must be a resident of Washington state;
- You must have been rejected for coverage by an insurance carrier based upon the results of the Standard Health Questionnaire, or live in a Washington state county where individual health benefit plans are not offered; and
- You must not be eligible for Medicare coverage.

Contents of this Enrollment Packet

1. 2008 Non-Medicare Plan Comparison Chart
2. Summary of Benefits for WSHIP Non-Medicare plans:
 - Standard Plan
 - Preferred Provider Plan
 - HSA Qualified Preferred Provider Plan (Health Savings Account)
 - Limited Preferred Provider Plan "A"
 - Limited Preferred Provider Plan "B"
3. Application for Coverage
4. Application Checklist
5. 2008 Non-Medicare Plans Monthly Premium Rates
6. Low Income Discount Application
7. WSHIP Privacy Notice
8. WSHIP Appeals by Applicants and Participants
9. Agent Directory

How to Contact Us

- **By Phone** (8:00 a.m. – 5:00 p.m. Pacific Time): 1-800-877-5187
- **By Fax:** 1-620-792-7053
- **Via Mail:** WSHIP, P.O. Box 1090, Great Bend, KS 67530
- **On the Web:** www.wship.org

**Washington State Health Insurance Pool (WSHIP)
2008 NON-MEDICARE PLAN COMPARISON**

Medical Deductibles, Cost Shares, Limitations	Standard Plan	Preferred Provider Plan	HSA Qualified Preferred Provider Plan (Health Savings Account)	Limited Preferred Provider Plan "A"	Limited Preferred Provider Plan "B"
Annual Deductible (Individual)	Choices: \$500, \$1,000 or \$1,500 (Medical only)	Choices: \$500, \$1,000, \$2,500 or \$5,000 (\$2,500 and \$5,000 plans have a separate \$500 Prescription Drug deductible)	\$3,000 (Combined Medical and Prescription Drug deductible)	\$1,500 (Medical only)	\$1,500 (Medical only)
Coinsurance	20%	20% Network 40% Non-Network	20% Network 40% Non-Network	20% Network 40% Non-Network	20% Network 40% Non-Network
Annual Out-of-Pocket Expense Limits (Individual) Includes deductible and coinsurance/copays	\$500 Plan: \$1,000 Medical \$ 500 Prescription Drug \$1,000 Plan: \$1,650 Medical \$ 850 Prescription Drug \$1,500 Plan: \$2,000 Medical \$1,000 Prescription Drug	\$500 Plan: \$1,000 Network \$2,000 Non-Network \$ 500 Prescription Drug \$1,000 Plan: \$1,650 Network \$3,300 Non-Network \$ 850 Prescription Drug \$2,500 Plan: \$5,000 Network \$7,500 Non-Network \$5,000 Prescription Drug \$5,000 Plan: \$10,000 Network \$15,000 Non-Network \$ 5,000 Prescription Drug	\$ 5,250 Network \$10,500 Non-Network (Combined Medical and Prescription Drug out-of-pocket expense limit)	\$4,000 Network \$6,000 Non-Network	\$6,500 Network \$9,750 Non-Network
PRESCRIPTION DRUGS	\$500 Plan: \$15 Brand / \$7 Generic \$1,000 Plan: \$20 Brand / \$10 Generic \$1,500 Plan: \$25 Brand / \$12 Generic	\$500 Plan: \$15 Brand /\$7 Generic \$1,000 Plan: \$20 Brand / \$10 Generic \$2,500 and \$5,000 Plan: \$500 Deductible 50% NonPreferred Brand 30% Preferred Brand 20% Generic	20%	50% NonPreferred Brand 30% Preferred Brand \$10 Generic (copay) Benefit Maximum: \$3,000	50% NonPreferred Brand 30% Preferred Brand \$10 Generic (copay) Benefit Maximum: \$2,000

COINSURANCE / LIMITATIONS

MEDICAL BENEFITS	Standard Plan	Preferred Provider Plan	HSA Qualified Preferred Provider Plan	Limited Preferred Provider Plan "A"	Limited Preferred Provider Plan "B"
		<i>Network / Non-Network</i>	<i>Network / Non-Network</i>	<i>Network / Non-Network</i>	<i>Network / Non-Network</i>
Acupuncture	20% 12 visits per calendar year	20% / 40% 12 visits per calendar year	20% / 40% 12 visits per calendar year	20% / 40% 12 visits per calendar year	20% / 40% 8 visits per calendar year
Care Management	No charge	No charge	No charge	No charge	No charge
Diabetes Education	10%	10%	10%	10%	10%
Diagnostic Services	20%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
Emergency Room	20%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
Home Health Care	20% 130 visits per calendar year	20% / 40% 130 visits per calendar year	20% / 40% 130 visits per calendar year	20% / 40% 130 visits per calendar year	20% / 40% 130 visits per calendar year
Hospice / Respite Care	20%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
Hospital Inpatient and Outpatient	20%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
Massage Therapy	20% 12 visits per calendar year	20% / 40% 12 visits per calendar year	20% / 40% 12 visits per calendar year	20% / 40% 12 visits per calendar year	20% / 40% 12 visits per calendar year
Maternity Services	20%	20% / 40%	20% / 40%	20% / 40%	NOT COVERED
Medical Supplies and Equipment *	20%	20% / 40%	20% / 40%	20% / 40% \$2,500 per calendar year	20% / 40% \$2,500 per calendar year
Medical Therapies	20%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
Mental Conditions and Chemical Dependency (inpatient and outpatient)	20% 30 days per calendar year 28 visits per calendar year	20% / 40% 30 days per calendar year 28 visits per calendar year	20% / 40% 30 days per calendar year 28 visits per calendar year	20% / 40% 30 days per calendar year 28 visits per calendar year	20% / 40% 30 days per calendar year 28 visits per calendar year
Oral Surgery	20%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
Preventive Care	20% \$400 per calendar year	20% / 40% \$400 per calendar year	20% / 40% \$400 per calendar year	20% / 40% \$400 per calendar year	20% / 40% \$400 per calendar year
Professional Services (includes surgical and anesthesia)	20%	20% / 40%	20% / 40%	20% / 40%	20% / 40%
Rehabilitation Therapies	20%	20% / 40%	20% / 40%	20% / 40% 30 visits per calendar year	20% / 40% 20 visits per calendar year
Skilled Nursing Facility	20% 100 days per calendar year	20% / 40% 100 days per calendar year	20% / 40% 100 days per calendar year	20% / 40% 60 days per calendar year	20% / 40% 30 days per calendar year
Spinal Manipulations	20%	20% / 40%	20% / 40%	20% / 40% 10 visits per calendar year	20% / 40% 10 visits per calendar year
Transplant Surgery *	20% \$250,000 lifetime maximum	20% \$250,000 lifetime maximum	20% \$250,000 lifetime maximum	20% \$250,000 lifetime maximum	20% \$250,000 lifetime maximum

* *Pre-approval required*



APPLICATION for COVERAGE

Washington State Health Insurance Pool

Use for all Non-Medicare Plans

MAIL APPLICATION TO:

BMI (Benefit Management, Inc.)
 P.O. Box 1090, Great Bend, KS 67530
 1-800-877-5187 or www.wship.org

Please type or print in black ink. All questions must be filled out with complete detail (attach a separate piece of paper if necessary). Incomplete applications may delay the effective date of your policy. If you have questions while completing the application, call WSHIP Customer Service at **1-800-877-5187**.

INFORMATION AND PREMIUM RATES CONTAINED HEREIN ARE SUBJECT TO CHANGE WITH A 30-DAY NOTIFICATION.

SECTION I: AGENT INFORMATION

IF APPLICATION IS BEING MADE THROUGH AN AGENT, THE AGENT MUST PROVIDE THE INFORMATION BELOW. RETURN THIS FORM WITH YOUR APPLICATION.

Agent Name:	Firm or Agency:
Agent Address:	
Agent Phone: ()	Agent email address:
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 and the Standard Health Questionnaire (if applicable) has been completed truthfully by the Applicant(s).	
Agent Signature	Date
Agent's Washington State License No:	<input type="checkbox"/> Copy of License Attached <input type="checkbox"/> Copy of current license on file with WSHIP
Agent's Tax I.D. Number:	Contact Person: ()
<input type="checkbox"/> Pay commission to agent OR <input type="checkbox"/> Pay commission to firm	
A copy of the agent's current Washington state license and a W-9 form must be submitted with this application, or be on file with WSHIP, to receive agent commission payment from WSHIP.	

SECTION II. APPLICANT INFORMATION

Last Name _____ First Name _____ MI _____

Social Security Number _____

Street Address (**required**) _____

City _____ State _____ Zip Code _____

County of Residence _____

 Male Female Birth Date ____ / ____ / ____ Age _____

Home Telephone _____ Work Telephone _____

Email address _____

Custodial Parent / Guardian if Applicant is a minor or not legally competent:

Billing Address and Name of Organization / Agency Responsible for Payment, if different from above:

Organization Name _____

Billing Address _____

City _____ State _____ Zip _____

Contact person _____ Phone _____

Receiving DSHS Medical Assistance? _____ Yes No**SECTION III: PLAN SELECTION**

Please check the plan and corresponding deductible you are selecting. **Please Note: Changing plans can only be done effective January 1st each year.** (Exceptions may be made, upon review, under special circumstances.) **When changing plans, your deductible may not be decreased nor may you elect to move to a more comprehensive non-Medicare plan.**

Select your Plan and Deductible choice: **STANDARD PLAN**

Deductible choices:

- \$ 500 deductible
 \$1,000 deductible
 \$1,500 deductible

 PREFERRED PROVIDER PLAN

Deductible choices:

- \$ 500 deductible
 \$1,000 deductible
 \$2,500 deductible
 \$5,000 deductible

PLAN SELECTIONS continued on next page...

SECTION III: PLAN SELECTION continued...

- HSA QUALIFIED PREFERRED PROVIDER PLAN**
\$3,000 deductible
- LIMITED PREFERRED PROVIDER PLAN "A"**
\$1,500 deductible
- LIMITED PREFERRED PROVIDER PLAN "B"**
\$1,500 deductible (no maternity coverage)

SECTION IV. DEPENDENT INFORMATION

If you are eligible for WSHIP and enroll, you can elect to cover your dependent children. They do not have to be rejected by an insurance carrier. List dependents to be covered. Dependent children must be unmarried, and under age 19 (unless disabled). Additional premiums are required for each dependent.

Dependent A

Last Name _____ First Names _____ MI _____

Social Security Number _____ Birth Date ____/____/____

Disabled and 19 or older? **Yes** **No**

If yes, receiving Social Security disability? **Yes** **No** Entitlement date ____/____/____

Receiving DSHS medical assistance? **Yes** **No** Relationship to Applicant _____

Dependent B

Last Name _____ First Names _____ MI _____

Social Security Number _____ Birth Date ____/____/____

Disabled and 19 or older? **Yes** **No**

If yes, receiving Social Security disability? **Yes** **No** Entitlement date ____/____/____

Receiving DSHS medical assistance? **Yes** **No** Relationship to Applicant _____

Add an additional sheet if you have more dependents.

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

If **YES**, name of person(s): _____

Relationship: _____ Policy Number: _____

SECTION V. ELIGIBILITY INFORMATION

I CERTIFY that I am eligible for coverage because I meet the following 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. **You must attach evidence of residency with this application. The evidence must match the home address listed in Section II, P-2.** Evidence of residency includes, but is not limited to, a copy of:

- a) A bill in your name from any public utility at your dwelling in the state of Washington; or
- b) Receipts for rent, mortgage or lease payments for your dwelling in Washington state; or
- c) A Washington state drivers license or state identification card; or
- d) Proof of registration and payment in Washington of taxes and fees on motor vehicles; or
- e) Proof of employment in Washington state; or
- f) A voter registration card; or
- g) A federal tax return as a resident of Washington state.

(2) I also meet one of the **ELIGIBILITY CATEGORIES** listed below. Please check the eligibility category you are applying under.

REJECTION FOR OTHER HEALTH COVERAGE FOR MEDICAL REASONS

I have received notification of rejection for coverage from a Washington state licensed insurance carrier based on the results of the Standard Health Questionnaire (SHQ). A copy of the insurance carriers’ rejection notice and SHQ scoring page are attached to my WSHIP application. WSHIP will accept a denial notice for up to 90 days from the date of the denial. Applicants may be required to reapply to a health carrier if the denial was received more than 90 days from the WSHIP application date.

COUNTY WITHOUT INDIVIDUAL COVERAGE

I reside in one of the state of Washington counties where individual health benefit plans are not marketed to the general public by an insurance carrier. Name of county: _____

NO PERSON IS ELIGIBLE FOR WSHIP COVERAGE IF ONE OF THE FOLLOWING APPLIES TO THEM:

- a) They have terminated coverage in WSHIP within the last 12 months, unless they can show that they had continuous other coverage from the date WSHIP coverage terminated, which has been involuntarily terminated for any reason other than non-payment of premiums;
- b) WSHIP has paid out two million dollars in benefits on their behalf;
- c) They are an inmate of a public institution;
- d) Their benefits are duplicated under public programs; or
- e) They do not reside in Washington state (except qualified resident dependent children temporarily living outside of Washington state).

SECTION VI. 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 including public programs such as Medicare or Medicaid? **Yes** **No**

If **YES**, complete the following for each person(s) (use an additional page if needed):

Last Name First Name MI

Insurance Company Name

Insurance Company Phone No.

Policy Number

Description of Coverage

Is it a Group Plan? Yes No

Is it your intent to replace it with this coverage? Yes No

SECTION VII. 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. (See below.) To help us determine if you qualify for shortening the pre-existing condition waiting period, please complete the following information and **attach your Certificate of Coverage from your current or prior 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 insurance carrier), to demonstrate prior coverage beginning and ending dates.

Name of carrier (insurance company): _____

Telephone Number of carrier: _____

Name of subscriber (contract holder): _____

ID Number of subscriber: _____

Names of all enrollees on prior coverage: _____

Date coverage began: _____ **Date coverage ended:** _____

Deductible amount: \$ _____

Out-of-pocket maximum amount per year: \$ _____

Type of coverage: Individual Group Healthy Options Basic Health Plan

Type of benefits (check all that apply): Medical Hospital Only Accident Only

Do you intend to continue this other coverage if you are accepted by WSHIP?

YES NO (If no, you must contact your insurance company to cancel.)

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 \$1,750 or more deductible or \$3,500 or more out-of-pocket cost 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 VIII. DISCLOSURE CERTIFICATION

THIS FORM MUST BE SIGNED BY ALL ADULT APPLICANTS.

By signing this form, I, as an adult Applicant, certify the following:

- a) All of the answers provided for all persons listed as Applicants are true and complete.
- b) I understand that anyone who submits false information may lose coverage, may be held financially responsible for services obtained under WSHIP coverage, coverage may be terminated or rescinded as of the effective date, and I may face other penalties for prosecution and collection. WSHIP may also refund premiums previously paid and recover claims and administrative costs from you or other persons responsible for the intentionally false information.
- c) WSHIP coverage will not be effective until this application has been signed, submitted in full by the Applicants and approved by WSHIP, and the first month's premium has been paid. Deposit of premium payment does not guarantee coverage. The payment will be refunded for Applicants who are not eligible for WSHIP coverage.
- d) I have read the Privacy Notice at the end of this brochure.
- e) **I understand that once I have selected my plan and deductible, I cannot move to a lower deductible or a more comprehensive non-Medicare plan at a later date.**
- f) If I have designated someone as my personal representative, I have included the signed Personal Representative Form with this application.

SIGNATURE OF APPLICANT OR CUSTODIAL PARENT IF APPLICANT IS UNDER AGE 18 OR NOT LEGALLY COMPETENT:

Signature

Date

Print Name

SECTION IX. PREMIUM PAYMENT

PLEASE CHOOSE ONE OF THE PREMIUM PAYMENT OPTIONS BELOW:

- MONTHLY BANK DRAFT** – 1 month premium due with application.
(Complete attached Authorization Form and include a VOIDED check.)
- QUARTERLY** – 3 months premium due with application.
- SEMI-ANNUAL** – 6 months premium due with application.
- ANNUAL** – 12 months premium due with application.

MAKE CHECK PAYABLE TO WSHIP

- Use the RATE TABLES enclosed in your Enrollment Packet to determine your premium payment.
- **IMPORTANT: If you are applying for the low income discount, you must first submit the undiscounted premium with your application. If you are approved for the low income discount, your account will be credited.**

Please check below to indicate which **Premium Rate Table** you used to determine your payment:

Standard Plan	Preferred Provider Plan	HSA Qualified Preferred Provider Plan	Limited Preferred Provider Plan "A"	Limited Preferred Provider Plan "B"
<input type="checkbox"/> Table 1 <input type="checkbox"/> Table 2 <input type="checkbox"/> Table 3 <input type="checkbox"/> Table 4	<input type="checkbox"/> Table 1	<input type="checkbox"/> Table 1	<input type="checkbox"/> Table 1	<input type="checkbox"/> Table 1

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 prior** to the date of that change to have the change implemented the first of the next month.

SECTION X. EFFECTIVE DATE OF COVERAGE

Please note:

1. The "**Application Received by WSHIP**" date is determined as the date WSHIP receives a faxed copy of your application, or the postmark date of the application that you mailed to WSHIP, whichever occurs first.
2. 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.
3. Once the application is approved, your insurance coverage and premiums will begin on the first (1st) of the month based on your choice.

Select your effective date of coverage; check only one choice:

AS SOON AS WSHIP CAN PROCESS MY APPLICATION
 I understand that if my application is faxed or postmarked on or before the 20th of the month, then WSHIP coverage will be effective the 1st of the next month. However, if my application is faxed or postmarked after the 20th of the month, my coverage will not start until the 1st of the SECOND month. (Example: Application received by WSHIP July 21, 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. (For example, with a postmark date of May 2, your coverage can be effective no later than July 1.)

Tell WSHIP what your Future Date of Coverage should be:

(month) _____ (year) _____

AN EARLIER DATE

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

- a) You applied for individual coverage with a Washington state health insurance 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,
- b) You are mailing or faxing this WSHIP application within 15 days of receiving that carriers' Notice of Rejection.

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

Enter the date of the application to the other carrier _____

Enter Requested Effective Date here: (month) _____ (year) _____

SECTION XI. LOW INCOME DISCOUNTS

APPLICANTS MAY QUALIFY TO RECEIVE A LOW INCOME DISCOUNT IF THE FOLLOWING APPLIES:

- a) Gross family income is less than 301% of the Poverty Level Guidelines (see income tables at <http://aspe.hhs.gov/poverty/index.shtml> "2007 HHS Poverty Guidelines"; or call WSHIP, 1-800-877-5187 for more information.
- b) Washington state has funds available to support discounts.
- c) Discount does not result in a premium that is less than 110% of the Standard Risk Rate in Washington state for the same benefits.

If you think that you qualify for a discount, you may fill out a **WSHIP Low Income Discount Application**, which is included with this Enrollment Packet.

Discount Levels:

- 1. If gross family income of an Applicant is more than 250% but less than 301% of the Federal Poverty Level Guidelines, the discount is 15%.
- 2. If gross family income of an Applicant is less than 251% of the Federal Poverty Level Guidelines, the discount is 30%.

PREMIUM PAYMENT: If you are applying for the low income discount, you first must pay the amount of basic rates due for one month's premium without a discount in order to activate your coverage.

Do not fill out the application for Low Income Discount unless you believe you qualify for the discount. If your income status changes, you must notify WSHIP.

MAIL COMPLETED APPLICATION TO:

**WSHIP
ATTN: Enrollment
P.O. Box 1090
Great Bend, KS 67530**

**ALL PAGES (P1-P8) OF THE APPLICATION
MUST BE RETURNED**

**IF APPLICATION IS BEING MADE THROUGH AN AGENT,
RETURN THE SIGNED AGENT INFORMATION FORM (SECTION I).**

All necessary information must be included and appropriate documentation attached when requested in order for the application to be processed. An incomplete application will delay the approval process.

WASHINGTON STATE HEALTH INSURANCE POOL

**BANK SERVICE PLAN
AUTHORIZATION FORM**

TO: The financial institution named on the reverse side.

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 that 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



REQUEST FOR BANK SERVICE PLAN – AUTHORIZATION FORM

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 of:

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 15 days' written notice from me to revoke it.**

X _____ **X** _____
Authorized signature as shown on account Date

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's Customer Service Dept. at 1.800.877.5186.

ATTACH A VOIDED CHECK HERE:

Please return the Bank Service Plan to:
WASHINGTON STATE HEALTH INSURANCE POOL
P.O. BOX 1090, GREAT BEND, KS 67530

PERSONAL REPRESENTATIVE FORM

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 BMI, the plan administrator. This designation will not affect benefits, claims processing and payment, or eligibility status.

Type of Information

WSHIP and BMI 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 BMI, the health plan administrator.

Authorized Use and/or Disclosure

I authorize WSHIP and BMI 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 BMI 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 BMI has taken, or any information that has already been released based upon prior authorizations.

Designation of Personal Representative(s)

Name of Authorized Person	Relationship to Member	*Privacy Password
Name of Authorized Person	Relationship to Member	*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.

Signature of Member/Legal Representative

Date

Printed Name of Legal Representative

Description of Legal Representative’s
Relationship to Member

WSHIP NON-MEDICARE PLANS APPLICATION CHECKLIST

Contact WSHIP Customer Service Dept., 1-800-877-5187; or via email at www.wship.org if you have questions filling out your application form.

- Signature:** Is your application completely filled out and signed in black ink?
- Plan Selection:** Have you selected a Plan and corresponding Deductible choice?
- Applicant Information:** If you have a post office box, is a street address also included?
- Dependent Information:** Have you included premium payment for your dependents?
- Eligibility Information:** Have you selected your eligibility category and included a copy of the documentation for the category you checked?
- Proof of Residency:** Have you included proof of Washington state residency?
- Rejection notice and copy of Standard Health Questionnaire scoring page:** Have you included a copy of the rejection notice and the scoring page of the Standard Health Questionnaire returned to you by the insurance carrier? This scoring page must be included with your application.
- Other Coverage:** If this pertains to you, have you included the information about your other medical or hospital insurance, including Medicare or Medicaid?
- Pre-Existing Conditions:** If the Pre-existing Waiver Benefit applies to you and your coverage was an individual plan, did you include a Certificate of Creditable Coverage from your previous insurance carrier, or other documentation to demonstrate beginning and ending dates of that coverage? If prior coverage was on an individual plan, did you include a Summary of Benefits?
- Disclosure Certification:** Have you signed the form acknowledging you cannot switch to a lower deductible plan at a later date once you have made your plan selection?
- Premium Payment:** Did you identify a premium payment cycle (Monthly Bank Draft, Quarterly, Semi-Annual, or Annual), and have you checked the Premium Rate Table you used?
- Enclosure of Payment:** Have you included the premium payment due according to the payment cycle?
- Effective Date of Coverage:** Have you selected the date you wish your coverage to begin?
- Low Income Discounts: NOTE: If you are applying for the Low Income Discount, you first must pay the amount of basic rates due for one month's premium without a discount in order to activate your coverage.** If you are approved for the low income discount, your account will be credited. To apply for the Low Income Discount, submit the enclosed Low Income Application Form with your WSHIP Application.
- Bank Service Plan Authorization Form:** If you chose the Monthly Bank Draft premium payment cycle, did you include one month's premium? Did you complete, sign and enclose the "Request for Bank Service Plan – Authorization Form"? Did you attach a voided check?
- Personal Representative:** If you wish to designate a Personal Representative, have you filled out and signed the form?

**All necessary information must be included and appropriate documentation attached in order for application to be processed.
An incomplete application will delay the approval process.**