CHIP

ARKANSAS COMPREHENSIVE HEALTH INSURANCE POOL (CHIP)

____
Applicant's Name

P.O. Box 1460
Little Rock, AR 72203

Application for CHIP Coverage
Federally Eligible Individuals and Resident Eligible Persons

This Application for CHIP Coverage contains an Eligibility Worksheet and two Enrollment Forms. First, please answer the Eligibility Worksheet and follow its instructions. The Eligibility Worksheet helps you figure out if you may be eligible for CHIP coverage and shows you which Enrollment Form to fill out. Next, fill out the appropriate Enrollment Form. Finally, send both your completed Eligibility Worksheet and whichever Enrollment Form you fill out to CHIP Program, P.O. Box 1460, Little Rock, AR 72203.

ELIGIBILITY WORKSHEET

There are three ways that Arkansas residents may be eligible for CHIP coverage:

- **Federally Eligible Individual:** Under federal law, persons who have had health insurance coverage for at least 18 months without breaks in coverage of 63 days or more *may* qualify for CHIP coverage *that does not exclude pre-existing conditions.* Answer Part Two of this Eligibility Worksheet to determine if you qualify for this type of coverage.

- **Resident Eligible Person:** Persons who do not qualify as federally eligible individuals may still qualify for CHIP coverage as resident eligible persons if they have been residents of Arkansas for at least 90 days and have been rejected for coverage in the individual health insurance market because of a medical condition, or offered individual health insurance at substantially higher rates. You also may qualify as a resident eligible person if you recently were covered in another state by a health insurance risk pool similar to CHIP. The Eligibility Worksheet will direct you to Part Three of the Worksheet if you do not qualify as a federally eligible individual, but might qualify for coverage as a resident eligible person.

- **Persons eligible for the federal Health Coverage Tax Credit.** If you have received notice that you may be eligible for the Health Coverage Tax Credit, **STOP.** You must fill out a separate application. Please contact CHIP at 1-800-285-6477 for more information.

PART ONE: GENERAL INFORMATION

1. **Residency.** Are you currently a resident of Arkansas?

❑ Yes **If you answered YES, proof of residency MUST be submitted with this Application. Proof of residency includes written evidence such as a copy of your current driver's license, your most recent Arkansas tax return or utility bill. Continue with question 2.**

❑ No **If you answered NO, STOP. You are not eligible for CHIP coverage if you do not currently reside in Arkansas.**

2. **Citizenship status.** Are you a United States citizen or an alien lawfully admitted for permanent residence?

❑ Yes **If you answered YES, continue with question 3.**

❑ No **If you answered NO, STOP. You are not eligible for CHIP coverage.**

3. **In-patient at State Institution.** Are you currently a resident of a state institution?

❑ Yes **If you answered YES, STOP. You are not eligible for CHIP.**

❑ No **If you answered NO, continue with question 4.**

4. **Availability of Medicare.** Are you currently enrolled in, *or eligible for,* Medicare?

❑ Yes **If you answered YES, STOP. You are not eligible for CHIP coverage.**

❑ No **If you answered NO, continue with question 5.**

____
Applicant's Name

5. **Availability of Medicaid.** Are you currently enrolled in, *or eligible for,* coverage through Arkansas Medicaid or ARKids? ❑ Yes **If you answered YES, STOP. You are not eligible for CHIP coverage.** ❑ No **If you answered NO, continue with Part Two of this Worksheet.**

PART TWO: IS APPLICANT A FEDERALLY ELIGIBLE INDIVIDUAL?

1. **Availability of group or COBRA coverage.** Are you currently enrolled in, *or eligible for,* coverage through Medicare, Medicaid OR from a group health plan (group coverage provided by or through an employer), *including* COBRA or continuation coverage?

❑ Yes **If you answered YES, is your coverage scheduled to terminate?**

❑ Yes **If you answered YES, indicate the date your coverage will end: ________________ and continue with question 2.**

❑ No **If you answered NO, STOP. You are not eligible for CHIP coverage if you are enrolled in, or eligible for, coverage offered through a group health plan.**

❑ No **If you answered NO, continue with question 2.**

2. **Enrollment in other health insurance coverage.** Are you enrolled in any other form of health insurance coverage, such as coverage offered through an individual health insurance policy? (Health insurance coverage is defined in your Outline of Coverage.)

❑ Yes **If you answered YES, you are not a federally eligible individual. <u>Go to Part Three</u> of this Worksheet to see if you may qualify for CHIP coverage as a resident eligible person.**

❑ No **If you answered NO, continue with question 3.**

Creditable coverage.*

- To be a federally eligible individual, you must have had "creditable coverage" for at least 18 months without a break in coverage of 63 consecutive days or more. Your most recent coverage must have ended no more than 63 days before the date you complete this application.
- Creditable coverage includes most forms of health insurance, including individual coverage, coverage through group plans sponsored by an employer, the federal government or a state, COBRA or continuation coverage, and coverage provided under a qualified high risk pool such as CHIP. (Your Outline of Coverage contains definitions of "creditable coverage" and "qualified high risk pool".)*

3. Did your most recent creditable coverage end <u>more than 63 days</u> before the date you complete this application?

❑ Yes **If you answered YES, STOP. You are not a federally eligible individual. <u>Go to Part Three</u> of this Worksheet to see if may qualify for CHIP coverage as a resident eligible person.**

❑ No **If you answered NO, continue with question 4.**

4. Did the creditable coverage terminate because of nonpayment of premium or fraud?

❑ Yes **If you answered YES, STOP. You are not a federally eligible individual. <u>Go to Part Three</u> of this Worksheet to see if may qualify for CHIP coverage as a resident eligible person.**

❑ No **If you answered NO, continue with question 5.**

* "Creditable coverage" <u>does not</u> include the following types of coverage: accident-only, disability income, liability, auto (including auto medical payment), credit-only or workers compensation insurance; on-site clinic plans; dental-only or vision-only plans; long-term care plans; specific disease plans or hospital indemnity plans, when not offered in coordination with a group health plan; supplemental plans such as Medicare supplement, CHAMPUS supplement or hospital supplement plans.

5. Were you covered by the creditable coverage for 18 consecutive months or more?

❑ Yes **If you answered YES, go to question 6.**

❑ No **If you answered NO, were you covered by the creditable coverage for a <u>total</u> of at least 18 months without a break in coverage of 63 days or more?**

❑ Yes **If you answered YES, continue to question 6**.

❑ No **If you answered NO, STOP. You are not a federally eligible individual. <u>Go to Part Three</u> of this Worksheet to see if you may qualify for CHIP coverage as a resident eligible person.**

6. Did you receive your *<u>most recent</u>* health insurance coverage through a group health plan, COBRA, a governmental plan or church plan? (The definitions of these plans are included in your Outline of Coverage.)

❑ Yes **If you answered YES, please fill out the <u>Enrollment Form for a Federally Eligible Individual</u> beginning on page 5.**

❑ No **If you answered NO, STOP. You are not a federally eligible individual. <u>Go to Part Three</u> of this Worksheet to see if you qualify for CHIP coverage as a resident eligible person.**

PART THREE: IS APPLICANT A RESIDENT ELIGIBLE PERSON?

1. a. **New Resident previously covered by Risk Pool in another state.** Was your most recent health insurance coverage from a qualified high risk pool similar to CHIP in another state (the definition of "qualified high risk pool" is in your Outline of Coverage)?

❑ Yes **If you answered YES,** did your coverage in the other qualified high risk pool end within 63 days before the date you complete this application, for reasons <u>other than</u> fraud?

❑ Yes **If you answered YES, please identify the date your coverage ended ___________________, or attach a certificate of creditable coverage from the other state's risk pool.**

List the state in which you were covered ___________________________ ,

your policy or I.D. number ___________________________,

and a phone number for the risk pool administrator __________________________.

❑ No **If you answered NO, skip to question 2.**

❑ No **If you answered NO, skip to question 2.**

b. Have you resided in Arkansas for at least 30 days as of the date you submit this application?

❑ Yes **If you answered YES, proof that you have resided in the state for at least 30 days MUST be attached to this Application. Proof of residency includes written evidence such as a copy of your current driver's license, a recent Arkansas tax return or a utility bill. If you answered YES this question, please skip to question 3.**

❑ No **If you answered NO, STOP. You are not eligible for CHIP coverage as a resident eligible person.**

2. **Residency: General Rule.** Have you resided in Arkansas for at least 90 days as of the date you submit this application?

❑ Yes **If you answered YES, you MUST attach proof that you have resided in the state for at least 90 days before submitting this Application. Proof of residency includes written evidence such as a copy of your current driver's license, a recent Arkansas tax return or utility bills. Continue to question 3.**

❑ No **If you answered NO, STOP. You are not eligible for CHIP coverage as a resident eligible person.**

Applicant's Name

3. **Prior coverage by CHIP.** Have you previously had coverage through the Arkansas CHIP program?

❑ Yes **If you answered YES, continue with parts 3.a. and 3.b.**

a. Has your insurance through the Arkansas CHIP program been cancelled during the last 12 months?

❑ Yes **If you answered YES, STOP. You are not eligible for CHIP coverage after you voluntarily cancel coverage or have been cancelled for non-payment until 12 months have passed since the date your coverage terminated.**

❑ No **If you answered NO, continue to question 3.b.**

b. Have you previously received CHIP benefits totaling $1,000,000 or more?

❑ Yes **If you answered YES, STOP. You are not eligible for CHIP because you already have received the maximum health insurance coverage allowed for a resident eligible person.**

❑ No **If you answered NO, continue to question 4.**

❑ No **If you answered NO, continue to question 4.**

4. **Rejection for individual health insurance coverage because of a health condition.** Within the last 12 months, have you been rejected or refused by an insurer to issue substantially similar *individual* health insurance coverage by reason of the existence or history of a medical condition?

❑ Yes **If you answered YES, please attach a copy of the rejection notice from the insurer and fill out the <u>Enrollment Form for Resident Eligible Person</u> beginning on page 7.**

❑ No **If you answered NO, go to question 5.**

5. **Evidence of refusal to issue individual coverage except at substantially higher rate than CHIP coverage.** Has an insurer refused to offer you individual health insurance coverage except at a rate that is 50% higher than the CHIP plan with the same (or most similar) calendar year deductible as the more expensive coverage? (The rates for CHIP plans and the deductibles for each plan are contained on the rate sheet included in this application packet.)

❑ Yes **If you answered YES, provide an <u>outline of benefits and rates</u> for this other insurance, and fill out the <u>Enrollment Form for Resident Eligible Person</u> beginning on page 7.**

❑ No **If you answered NO, STOP. You are not eligible for CHIP.**

End of Eligibility Worksheet. Enrollment Forms begin on next page.

CHIP

P.O. Box 1460
Little Rock, AR 72203

ARKANSAS COMPREHENSIVE HEALTH INSURANCE POOL (CHIP)

Enrollment Form for a FEDERALLY ELIGIBLE Individual

Please Print All Information.

APPLICANT INFORMATION

LAST NAME	FIRST NAME	M.I.	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	DEDUCTIBLE (check one)
						❑$1,000 ❑$5,000 ❑$10,000 ❑$1,250 – HSA Qualified

RESIDENCE ADDRESS

Street				County
City	State	Zip Code	Daytime Phone No.	Other Phone No.

MAILING ADDRESS (IF DIFFERENT)

Street or P.O. Box		
City	State	Zip Code

BILLING MODE (Please Check One)

❑ Monthly Bank Draft (Monthly payment is by bank draft only. To sign up for monthly bank drafts, you MUST sign the authorization form in your packet and submit a voided check. If you do not submit these items with your Application, you will be billed quarterly.)

❑ Quarterly (After initial billing with your acceptance letter, you will be billed for three months' premium due each January 1, April 1, July 1 and October 1.)

PERSONAL INFORMATION

Disability. Are you totally disabled?† ❑ Yes ❑ No If YES, briefly describe your disability:
Do you receive SSDI? ❑ Yes ❑ No If YES, list the date your SSDI began: ________________________

Tobacco Use. Have you used tobacco products in the last 12 months, including any type of lighted pipe, cigar, cigarette or any other smoking equipment filled with tobacco, or any type of smokeless tobacco, such as snuff or chewing tobacco? ❑ Yes ❑ No

INFORMATION ABOUT YOUR PRIOR COVERAGE

1. You must attest on the following page of this form that (i) you have had 18 months of creditable coverage without a break of 63 days or more; and (ii) you will cooperate with CHIP in verifying the creditable coverage.
2. Do you have certificate(s) of creditable coverage showing that you have had 18 months of creditable group or COBRA coverage without a break of 63 days or more? ❑ Yes ❑ No **If you answered YES, please attach the certificates to this Application.**

If you answered NO, please provide other evidence you have of the creditable coverage(s), if any, such as evidence of benefit forms or premium invoices from the health insurer that covered you, and provide the following information for each health insurance policy or plan under which you were covered (attach additional sheets if necessary):

Name of Insurer/Group Health Plan:	Dates of Coverage:	Was this coverage provided through an employer? ❑ Yes ❑ No If YES, provide the name and phone number of the employer:

IMPORTANT INFORMATION ABOUT BILLING AND PAYMENT

1. **Rates.** The amount of your premiums may vary from other CHIP policyholders, depending on the deductible level you choose, your age, your gender and whether you have used tobacco products in the last 12 months. Premium rates change on your "0" and "5" birthdays (25, 30, 35, 40, etc.).
2. **Rate increases.** CHIP's rates may increase at other times as well. You will have 31 days' notice of any increase.

† A person applying for coverage is considered to be totally disabled if he or she is unable, because of an illness or injury, to perform the material and substantial duties of his or her job. The disability may be temporary or permanent.

CERTIFICATION

Please read carefully and sign below.

I hereby apply for CHIP coverage, as offered by the State of Arkansas. I understand and agree to everything listed below:

- I certify that all the information I have provided in this Application for CHIP Coverage (which includes the Eligibility Worksheet and this Enrollment Form) is true and complete. I understand that my coverage may be cancelled or rescinded if CHIP determines that I have provided false information.
- I specifically attest that as of the day I am completing this Application, I have at least 18 months of prior creditable health insurance coverage without a break in coverage of 63 days or more. I agree to cooperate with CHIP in verifying this creditable coverage.
- If I do not pay premiums in full within 31 days after the due date, coverage will end as of the date payment was due.
- I certify that I am residing in the State of Arkansas as of the date of this Application.
- I understand that if accepted, I will be issued a policy that explains my rights and responsibilities as a CHIP enrollee and that failure to follow the requirements of the policy may result in the cancellation of my coverage.
- I have read and understand the Outline of Coverage provided with this Application.
- I understand that for my Application to be complete, I must submit proof of residency as described in Part One of the Eligibility Worksheet and all information that I have in my possession showing that I have had 18 months of prior creditable health insurance coverage without a break in coverage of 63 days or more.

Any person who knowingly presents false information in an application for insurance, or knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and confinement in prison.

Signed at:	**City**	**State**	**ZIP**
Applicant's Signature	**X**	**Date Signed**	
Parent/Guardian's Signature (if policy for a minor/incompetent)	**X**	**Date Signed**	

Agent's Statement: I have a valid agent's or broker's license in the State of Arkansas for accident and health insurance. I have *assisted* the applicant in completing this Application for coverage with CHIP. To the best of my knowledge and belief, the information contained in this Application and this affirmation form is correct and complete. I certify that the applicant meets the CHIP eligibility standards.

Print Agent's Name	Social Security No.	Agency	Phone Number	
Agent's Signature & Date	Address	City	State	ZIP

FOR OFFICE USE ONLY (Do NOT write in this space.)

Division No.		Effective Date

End of Enrollment Form for Federally Eligible Individual. **Return this Enrollment Form with your Eligibility Worksheet.**

CHIP

P.O. Box 1460
Little Rock, AR 72203

ARKANSAS COMPREHENSIVE HEALTH INSURANCE POOL (CHIP)

Enrollment Form for a RESIDENT ELIGIBLE Person

Please Print All Information.

APPLICANT INFORMATION:

LAST NAME	FIRST NAME	M.I.	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	DEDUCTIBLE (check one)
						❑$1,000 ❑$5,000 ❑$10,000 ❑$1,250 – HSA Qualified

RESIDENCE ADDRESS

Street				County
City	State	Zip Code	Daytime Phone No.	Other Phone No.

MAILING ADDRESS (IF DIFFERENT)

Street or P.O. Box		
City	State	Zip Code

BILLING MODE (Please Check One)

❑ Monthly Bank Draft (Monthly payment is by bank draft only. To sign up for monthly bank drafts, you MUST sign the authorization form in your packet and include a voided check. If you do not submit these items with your Application, you will be billed quarterly.)

❑ Quarterly (After initial billing with your acceptance letter, you will be billed for three months' premium due each January 1, April 1, July 1 and October 1.)

PERSONAL INFORMATION

Disability. Are you totally disabled?‡ ❑ Yes ❑ No If YES, briefly describe your disability:
Do you receive SSDI? ❑ Yes ❑ No If YES, list the date your SSDI began: ____________________

Tobacco Use. Have you used tobacco products in the last 12 months, including any type of lighted pipe, cigar, cigarette or any other smoking equipment filled with tobacco, or any type of smokeless tobacco, such as snuff or chewing tobacco? ❑ Yes ❑ No

INFORMATION ABOUT OTHER HEALTH CARE COVERAGE

Do you currently have other individual health insurance coverage? ❑ Yes ❑ No

If you answered YES and you are approved for this CHIP policy, you MUST cancel your existing health insurance coverage after you meet CHIP's waiting period for coverage of pre-existing conditions.

PURCHASE OF RIDER WAIVING THE PRE-EXISTING CONDITION EXCLUSION

Unless you are eligible for and purchase a rider waiving the pre-existing exclusion period, you will not be covered for the first six months you are enrolled under this Policy for expenses incurred because of any condition if:

- The condition has manifested itself within the six (6) month period immediately preceding the effective date of coverage in such a manner as would cause an ordinary prudent person to seek diagnosis, care or treatment; or
- Medical advice, care or treatment was recommended or received within the six (6) month period immediately preceding the effective date of the coverage.

Please answer the following questions to see if you are eligible to purchase a rider waiving the six-month pre-existing exclusion period.

1. Have you had coverage for at least six months under a prior individual policy? ❑ Yes ❑ No
2. Have you satisfied the pre-existing condition exclusion under this prior individual policy? ❑ Yes ❑ No
3. Are you applying for CHIP coverage within 30 days after your prior individual coverage was *involuntarily* terminated by the insurance carrier? ❑ Yes ❑ No

If you answered NO to any of the three questions above you are not eligible for a waiver. If you answered YES to all three questions, you must submit a copy of the notice from the carrier canceling your coverage. You will be advised if additional documentation is necessary.

COST OF WAIVER: If you qualify for the Pre-existing Condition Exclusion Waiver, you may purchase the Waiver through paying a surcharge of 10% of your otherwise applicable annual premium for as long as your coverage under CHIP remains in effect, or sixty (60) months, whichever is less. The surcharge shall be charged monthly.

If you answered YES to all three questions above, do you want to purchase the Pre-Existing Rider if eligible? ❑ Yes ❑ No

‡ A person applying for coverage is considered to be totally disabled if he or she is unable, because of an illness or injury, to perform the material and substantial duties of his or her job. The disability may be temporary or permanent.

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1. **Rates.** The amount of your premiums may vary from other CHIP policyholders, depending on the deductible level you choose, your age, your gender and whether you have used tobacco products in the last 12 months. Premium rates change on your "0" and "5" birthdays (25, 30, 35, 40, etc.).
2. **Rate increases.** CHIP's rates may increase at other times as well. You will have 31 days' notice of any increase.

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Please read carefully and sign below.

I hereby apply for CHIP coverage, as offered by the State of Arkansas. I understand and agree to everything listed below:

- I certify that all the information I provided in this Application for CHIP Coverage (which includes the Eligibility Worksheet and this Enrollment Form) is true and complete. I understand that my coverage may be cancelled or rescinded if CHIP determines that I have provided false information.
- If I do not pay premiums in full within 31 days after the due date, coverage will end as of the date payment was due.
- I certify that as of the date of this Application I am a United States citizen or an alien lawfully admitted for permanent residence, and have resided in Arkansas as of the date of this Application for at least 90 days (or at least 30 days if my most recent coverage was though another state's qualified high risk pool) and I am applying within 63 days of when that other coverage was terminated).
- I certify that I am not a resident of a public institution and am not receiving a "benefit payment" from any government program.
- I certify that if I currently have other Individual health coverage, I will only keep it while I am satisfying the CHIP pre-existing condition waiting period.
- I understand that if accepted, I will be issued a policy that explains my rights and responsibilities as a CHIP enrollee and that failure to follow the requirements of the policy may result in the cancellation of my coverage.
- I have read and understand the Outline of Coverage provided with this Application.
- I understand that for my Application to be complete, I must submit proof of residency as described in Part One of the Eligibility Worksheet.
- **I understand that CHIP Program benefits will not be payable during the 6 months after coverage is effective for any condition that manifested itself in the six months prior to my Application for Coverage in such a manner that would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care or treatment was recommended or received during the 6 months prior to the effective date of CHIP coverage. I understand that in certain circumstances I may qualify for and purchase a waiver of the pre-existing condition exclusion with my application for this plan. I understand that pregnancy is one type of pre-existing condition. If I know, or should know from symptoms, that I am pregnant when I apply for CHIP coverage, I understand that services for routine maternity care benefits will be excluded during my first six months of coverage.**

Any person who knowingly presents false information in an application for insurance, or knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and confinement in prison.

Signed at:	**City**	**State**	**ZIP**
Applicant's Signature	**X**	**Date Signed**	
Parent/Guardian's Signature (if policy for a minor/incompetent)	**X**	**Date Signed**	

Agent's Statement: I have a valid agent's or broker's license in the State of Arkansas for accident and health insurance. I have *assisted* the applicant in completing this application for coverage with CHIP. To the best of my knowledge and belief, the information contained in this Application and this affirmation form is correct and complete. I certify that the applicant meets the CHIP eligibility standards.

Print Agent's Name	Social Security No.	Agency	Phone Number	
Agent's Signature & Date	Address	City	State	ZIP

FOR OFFICE USE ONLY (Do NOT write in this space.)

Division No.	Effective Date	Pre-Existing Waiver	Pre-Existing End Date
		_____ Yes _____ No	

End of Enrollment Form for Resident Eligible Person. **Return this Enrollment Form with your Eligibility Worksheet.**