

# MRMIP Enrollment Application Checklist

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Please use the following checklist to ensure that your application is complete:

- Review** the handbook to learn about the eligibility requirements for the California Major Risk Medical Insurance Program (MRMIP) and choose your health plan before completing the Enrollment Application.
- Complete** the Enrollment Application on pages 25-28 of this handbook. All questions must be fully answered. If you do not provide all necessary information (including the required documentation, signatures, and payments), your application will be incomplete, which will delay the processing of your application.
- Sign and date** the completed Enrollment Application on page 28.
- Attach** the following items (your entire application may be returned to you if you do not provide the following):
  - Your **supporting documentation** that indicates your eligibility for the MRMIP. (Page 2 of this handbook describes how eligibility can be demonstrated.)
    - Copy of denial for individual insurance within the previous 12 months; or
    - Copy of letter indicating involuntary termination of health insurance within the previous 12 months for reasons other than nonpayment of premium or fraud; or
    - Copy of letter indicating individual health insurance premium in excess of the MRMIP subscriber contribution amount.
    - If you are eligible for Medicare Part A and B, copy of a Medicare letter explaining that you are eligible solely because of end-stage renal disease.
    - If you are applying for deferred enrollment, copy of letter indicating when coverage ends.
  - A **check** for one month's contribution for subscriber and/or dependent for your chosen health plan. Make check payable to **California Major Risk Medical Insurance Program**. (Monthly subscriber and/or dependent contribution amounts are listed on pages 18-23 of this handbook). Payments that **do not equal the exact amount that is due** will delay the processing of your application.
  - Proof of Qualifying Prior Coverage** (if applicable) to waive all or part of your Exclusion/Waiting Period must be received prior to or with your first month's contribution for credit to be given. (Please see pages 4-5 of this handbook for more information.)
  - Insurance Agents or Brokers:** You must complete all boxes at the bottom of page 25 of the Enrollment Application to request reimbursement.
  - Mail** the completed Enrollment Application with your check and all necessary attachments to:

**California Major Risk  
Medical Insurance Program  
P.O. Box 9044  
Oxnard, CA 93031-9044**

## California Major Risk Medical Insurance Program Enrollment Application

**Instructions:**

Thank you for applying for the California Major Risk Medical Insurance Program. Please follow these instructions to allow us to better process your application.

- Read the handbook to learn about eligibility and choose your health plan before completing this application.
- You (the applicant/parent/legal guardian) must complete this application. You are solely responsible for its accuracy and completeness.
- All questions must be fully answered. **If you do not provide all necessary information (including the required supporting documentation, signatures, and payments), your application will be incomplete, which will delay the processing of your application or may result in a denial.**
- Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded.

Attach check to page 28 where indicated.  
 Please submit one month’s subscriber contribution for your chosen health plan  
 (refer to pages 18-23).  
 Regardless of which plan you choose, **make your check payable to  
 California Major Risk Medical Insurance Program.**

Submit check, application and all necessary documentation to:

*California Major Risk  
 Medical Insurance Program  
 P.O. Box 9044  
 Oxnard, CA 93031-9044*

**INSURANCE AGENT and BROKER:** If you assisted your client in completing this application, please complete this section. You must complete all boxes. You will not be paid if you do not complete this section prior to submission. Missing information cannot be submitted at a later date for payment. (Please see note to Agents on pages 2-3 of the handbook.) **Use blue or black ink only.**

Agent Name			CA Agent/Broker License No.	Tax I.D. No./Soc. Sec. No.
Street Address			I understand that no Agent payment will be made unless and until this applicant is enrolled in the Program.  <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	
City	State	Zip		
Phone No.		FAX No: (if available)		
			Signature	



**6. Program Eligibility: To be eligible for the Program you must answer “yes” to one of the first four questions. Provide a copy of a letter or formal written communication documenting all “yes” answers. (See page 2.)**

	Applicant		Dependent	
	Yes	No	Yes	No
1. Within the past 12 months, have you been denied individual health insurance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past 12 months, have you been involuntarily terminated from health insurance coverage for reasons other than fraud or non-payment of premium?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Within the past 12 months, have you been offered an individual premium higher than the rate for the first choice health plan listed on this application?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you currently ineligible, but anticipate becoming eligible, and want to apply for a deferred enrollment? (See page 2.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you and your dependent(s), if any, met the requirements to waive all or part of the exclusion/waiting period? (See pages 4-5) under “How You May Waive All or Part of the Exclusion/Waiting Period.”) Please provide a copy of supporting documentation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of prior insurance company: _____				
Effective date of prior coverage: _____				
Termination date of prior insurance: _____				
6. Within the past 12 months, were you covered in a similar high risk pool sponsored by another state before becoming a California resident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**7. Declarations: Please read each of the following statements carefully and initial each statement. Any untrue or inaccurate responses may be reason for loss of enrollment or application of other sanctions.**

	Applicant Initials	Dependent Initials
1. I declare that no individual listed on this application is eligible for <b>both</b> Part A (hospital) and Part B (professional) of Medicare. If you <b>are</b> eligible solely because of end-stage renal disease, leave blank and provide Medicare eligibility letter as proof of end-stage renal disease. (Medicare is a federal program that provides health services to older Americans and disabled persons.)	<input type="text"/>	<input type="text"/>
2. I declare that all individuals listed on this application are residents of the state of California. (See page 2 under “Eligibility” for the definition of California resident.)	<input type="text"/>	<input type="text"/>
3. I declare that I am not currently eligible to purchase any health insurance for continuation of benefits from my employer under the provisions of 29 U.S. Code 1161 et seq. (COBRA), or under the provisions of Insurance Code Sections 10128.50 et seq. and Health and Safety Code Sections 1366.20 et seq. (Cal-COBRA). These are the laws which allow people to buy into their employer’s health insurance for at least 36 months after they leave their employer. (If you <b>are</b> currently on COBRA, leave blank and refer to page 2.)	<input type="text"/>	<input type="text"/>
4. I declare that all individuals listed on this application will abide by the rules of participation, the utilization review process and the dispute resolution process of the participating health plan in which the individual is enrolled. A dispute resolution process may include binding arbitration rather than a court trial to resolve any claim, including a claim for malpractice, asserted by me, my enrolled dependents, heirs, personal representatives, or someone with a relationship to us, against the participating health plan, or against the employees, partners, or agents, of the participating health plan.	<input type="text"/>	<input type="text"/>
5. I declare that I have reviewed the benefits offered by the MRMIP and the subscriber contribution amounts.	<input type="text"/>	<input type="text"/>
6. I declare that no individual listed on this application was excluded from group health coverage solely for the purpose of being made eligible for the MRMIP.	<input type="text"/>	<input type="text"/>
7. I declare that I understand and will follow the rules and regulations of the MRMIP. I understand that depositing a subscriber contribution check shall not constitute acceptance on the part of the MRMIP, or any of its subcontractors, if the application is not approved or if the member has already been disenrolled for nonpayment of subscriber contribution, fails to meet program eligibility requirements, commits program fraud, or because the dependent ceases to be a dependent, upon request by the member, or for any other reason.	<input type="text"/>	<input type="text"/>
8. I declare that I have not been terminated within the last 12 months from a Post-MRMIP Graduate health plan, which became available through guaranteed coverage after my eligibility for MRMIP ended (Health and Safety Code Section 1373.62 or Insurance Code Section 10127.15) due to nonpayment of premiums, as a result of my request to voluntarily disenroll, or as a result of fraud.	<input type="text"/>	<input type="text"/>

## 8. Authorization and Conditions of Enrollment

Required by the Confidentiality of Medical Information Act of 1/1/80, Sect 56 et seq. of the California Civil Code for all applicants of 18 years and over. I authorize any insurance company, physician, hospital, clinic or health care provider to give Major Risk Medical Insurance Program Administrator any and all records pertaining to any medical history, services or treatment provided to anyone listed on this application for purpose of review, investigation or evaluation. This authorization becomes immediately effective and shall remain in effect as long as Administrator requires. A photocopy of this Authorization is as valid as the original.

### Privacy Notification

The Information Practices Act of 1977 and the Federal Privacy Act require this Program to provide the following to individuals who are asked by the Major Risk Medical Insurance Program (established by Part 6.5 of Division 2 of the Insurance Code) to supply information: The principal purpose for requesting personal and medical information is for subscriber identification and program administration. Program regulations (Chapter 5.5 of Title 10 of the California Code of Regulations, Sections 2698.100 et seq.) require every individual to furnish appropriate information for application to the Major Risk Medical Insurance Program. Failure to furnish this information may result in the return of the application as incomplete. The following information on the application is voluntary: social security number, race/ethnicity information and health history.

Personal information provided on this form will not be furnished to any other governmental agency.

An individual has a right of access to records containing his/her personal information that are maintained by the Major Risk Medical Insurance Program. The official responsible for maintaining the information is: Deputy Director, Eligibility, Enrollment and Marketing, Managed Risk Medical Insurance Board, PO Box 2769, Sacramento, CA 95812-2769. The Board may charge a small fee to cover the cost of duplicating this information.

**I understand that this is a state program and my rights and obligations under it will be determined under Part 6.5 Division 2 of the California Insurance Code and at the regulation of Title 10, Chapter 5.5**

**I understand that if this application is approved, the effective date of coverage will be determined according to applicable laws and regulations and I will be informed in writing of the effective date. (Do not cancel any current coverage until you hear from MRMIP.)**

**I understand that there may be waiting periods for pre-existing conditions.**

**Each plan has its own rules for resolving disputes about the delivery of services and other matters. Some plans say you must use binding arbitration for disputes; others do not. Some plans say that claims for malpractice must be decided by binding arbitration; others do not. If the plan you choose requires binding arbitration, you are giving up your right to a jury trial and cannot have the dispute decided in court. To find out more about how a plan resolves disputes, you can call the plan and request an Evidence of Coverage or Certificate of Insurance booklet.**

**These plans DO NOT require binding arbitration: Blue Shield Access+ HMO and Contra Costa Health Plan.**

**These plans DO require binding arbitration of disputes: INCLUDING malpractice, so long as the disputes are beyond the jurisdictional limit of the small claims court: Blue Cross of California and Kaiser Permanente.**

**I, the applicant, declare that I have read and understand the information on this form and agree to the Authorizations and Conditions of Enrollment. I certify that the information provided on this application is true and correct.**

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Signature of Applicant/Parent or Legal Guardian Required	Date	Signature of Applicant's Spouse/Registered Domestic Partner Required (If listed on this application)	Date
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Signature of Applicant's Dependent Age 18 or over Required (If listed on this application)	Date	Signature of Applicant's Dependent Age 18 or over Required (If listed on this application)	Date

After filling out the application, signing and securing all necessary documentation, submit a check for one month's contribution for your chosen health plan.

**Make your check payable to California Major Risk Medical Insurance Program.**

Mail your complete application to:

California Major Risk  
Medical Insurance Program  
P.O. Box 9044  
Oxnard, CA 93031-9044