

## **INSTRUCTIONS FOR COMPLETION OF THE HIGH RISK APPLICATION**

1. A separate application must be completed for each person who is applying for coverage. Individual policies will be issued to each person enrolled. There is no group coverage available.
2. **Answer ALL questions on this application.** Read each question carefully before providing an answer. It is essential that LHP receive accurate and detailed information. Your application will not be processed unless all of the information is received.
3. **You must sign and date each page of the application. You must additionally sign and date the two written denials of coverage.** OR, an agent can write a letter on his letterhead naming two different insurance companies that he has contacted and state that coverage is not available because of pre-existing health conditions. Further, any additional attachments must be signed and dated as well.
4. You must select Plan A, Plan B, Plan C or Plan D. Plan A has a \$1,000 deductible, Plan B has a \$2,000 deductible, Plan C has a \$3,500 deductible, and Plan D has a \$5,000 deductible.
5. Plan A, Plan B, Plan C, and Plan D have separate Premium Rates found on a separate page. Please make sure that you choose the correct rate table. Also, make sure that you are looking at the correct age category, male/female category, and smoker/non-smoker category. Zip codes beginning in the 700 or 701 will utilize the New Orleans rates. Zip codes beginning with 707, 708, 710, or 711 will utilize the Baton Rouge/Shreveport rates. If your zip code does not begin with any of those listed, please use the "Other" category.
6. **You must enclose a check for one month's premium with your application. Make sure that your personal check is made payable to the Louisiana Health Plan and that it is dated and signed.** Checks will not be considered as "paid" until cleared.
7. **We suggest that you send your application certified mail, return receipt requested so that you will have proof of mailing and receipt.** We will only accept applications by mail. NO APPLICATIONS WILL BE ACCEPTED BY DELIVERY AT THE LOUISIANA HEALTH PLAN OFFICE. A videotape recording of the application receipt process will be made to ensure assignment and that all mail received on the same day is treated equally.
8. **You will be notified by mail of your application number.** Please do not contact the Louisiana Health Plan office. The staff is not permitted to release this information over the phone.
9. If you have any questions regarding the description of your medical condition, please contact your doctor's office. Staff can usually assist you in providing the necessary information you might need. Most of the information should be readily available to persons who are applying for coverage with Louisiana Health Plan without having to contact your doctor.
10. Please make sure that you read the application information and questions carefully and answer them honestly and completely. Any false statements can result in loss of coverage.
11. If after careful consideration, you do not understand any questions or request on the application, you may contact the Louisiana Health Plan office at the address and telephone number provided.

**APPLICATION FORM  
to the High Risk Pool  
LOUISIANA HEALTH PLAN**

**Mail To:**  
Louisiana Health Plan  
P. O. Drawer 83880  
Baton Rouge, LA 70884-3880

**Telephone Inquiries:**  
(225) 926-6245  
1-800-736-0947

I hereby apply for the Louisiana Health Plan (LHP). I understand that LHP Plan A has a calendar year deductible of \$1,000 and that I have a co-payment (coinsurance) responsibility of 25 percent with a stop-loss limit (including deductible) of \$4,500. I understand that LHP Plan B has a calendar year deductible of \$2,000 and that I have a co-payment (coinsurance) responsibility of 25 percent with a stop-loss limit (including deductible) of \$6,500. I understand that LHP Plan C has a calendar year deductible of \$3,500 and that I have a co-payment (coinsurance) responsibility of 25 percent with a stop-loss limit (including deductible) of \$8,000. I understand that LHP Plan D has a calendar year deductible of \$5,000 and that I have a co-payment (coinsurance) responsibility of 25 percent with a stop-loss limit (including deductible) of \$9,500. **I understand that there is a six month pre-existing condition waiting period under all plans (except as may be provided in question II(c) below) during which time claims for conditions which pre-existed my coverage will not be covered.** I understand that, if approved, I will receive a copy of the policy which will describe in detail all benefits, limitations, exclusions, and other needed information. **I will have 10 days to examine the policy and to ask any questions from my legal counsel.** If I decide that I do not want coverage with Louisiana Health Plan for any reason, I may return the policy for a full refund of premium. **Further, I understand that a false statement or misrepresentation on this application may result in loss of coverage. I enclose payment for one month's premium.**

Note: In order for your application to be processed, you must answer each question in detail, including all medical information. No medical condition will preclude you from obtaining coverage through Louisiana Health Plan (LHP). All medical information provided by you will not be subject to any public records examination and will be held as confidential by the Louisiana Health Plan.

**Please type or print in ink.** Use additional paper if necessary. Please sign and date any attachments to this form. If you have any questions completing the application, please call the number provided above.

**Part I INFORMATION ON APPLICANT TO BE COVERED**

**I am applying for:**      **\$1,000 Deductible**      **\$2,000 Deductible**      **\$3,500 Deductible**      **\$5,000 Deductible**  
**(check one)**              **Plan A** \_\_\_\_\_      **Plan B** \_\_\_\_\_      **Plan C** \_\_\_\_\_      **Plan D** \_\_\_\_\_

A. Name of Applicant \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
(Last) (First) (Middle Initial)

B. Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ E-mail \_\_\_\_\_  
(Month/Day/Year)

C. Address \_\_\_\_\_ Telephone \_\_\_\_\_  
(Street) (Area Code) (Day/Night)

\_\_\_\_\_  
(City) (State) (Zip Code) (Parish)

\_\_\_\_\_  
Date Signature

**Part II ELIGIBILITY REQUIREMENTS:**

- A. Residency: (All applicants must meet this requirement.)  
(1) Applicant must be a resident of the State of Louisiana for six months prior to this application.  
(2) Applicant must accompany this enrollment form with at least one of the following documents or other evidence of residency: copy of a current drivers license, rent receipts, mortgage payment receipts, property tax receipts, or utility bills for the past six months.

**I have been a resident of the State of Louisiana continuously since:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Month) (Day) (Year)

- B. Applicant received two written notices of refusal to issue insurance coverage from an insurance company or self-insured arrangement within one year of the date of filing this application.

**You MUST attach copies of these two written denials of coverage to this application or your application will not be processed.**

- C. If you had health insurance coverage with a health insurance company or self-insured arrangement which was involuntarily terminated for reasons other than non-payment of premium, please indicate the date in which coverage was involuntarily terminated: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Month) (Day) (Year)

- D. Are you eligible and/or enrolled in Medicare? \_\_\_\_ Yes \_\_\_\_ No

If yes, Identification Number: \_\_\_\_\_

Part A Effective Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Part B Effective Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Month) (Day) (Year) (Month) (Day) (Year)

- E. Are you eligible and/or enrolled in Medicaid? \_\_\_\_ Yes \_\_\_\_ No

Identification Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Month) (Day) (Year)

- F. Do you have any other hospital or medical insurance? \_\_\_\_ Yes \_\_\_\_ No

If yes, Name of Insurance Company: \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
(Street) (Area Code) (Number)

\_\_\_\_\_  
(City) (State) (Zip Code)

- G. Are you employed? \_\_\_\_ Yes \_\_\_\_ No If yes, by whom? \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Street Area Code Number

\_\_\_\_\_  
City State Zip Code

- (1) Does your employer offer group health insurance coverage? \_\_\_\_ Yes \_\_\_\_ No

- (2) If yes, give the following information regarding the health insurance company:

Name of Company: \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
(Street) (Area Code) (Number)

\_\_\_\_\_  
City State Zip Code

- (3) If yes, have you been denied coverage through the group health insurance carrier? \_\_\_\_ Yes \_\_\_\_ No

- (3) If yes, the reasons given, if any: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

H. Is your spouse (or in the case of a minor child, any parent) employed? If so, by whom?

Name of Company: \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
(Street) (Area Code) (Number)

\_\_\_\_\_  
(City) (State) (Zip Code)

(1) Does his/her employer offer group health insurance coverage? \_\_\_\_Yes \_\_\_\_No

(2) If yes, give the following information regarding the group health insurance company:

Name of Company: \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
(Street) (Area Code) (Number)

\_\_\_\_\_  
(City) (State) (Zip Code)

(3) If yes, have you (or your minor child) been denied coverage through the group health insurance carrier?  
\_\_\_\_Yes \_\_\_\_No

If yes, the reasons given, if any: \_\_\_\_\_

I. If your health care benefits with an employer have been terminated for any reason, please give the date of the termination of benefits: \_\_\_\_\_ (month, day, year)

(1) Are you receiving or are you eligible for COBRA benefits? \_\_\_\_Yes \_\_\_\_No

J. Are you an inmate of a public institution? \_\_\_\_Yes \_\_\_\_No

K. Are you currently insured by a high risk health insurance pool in another state? \_\_\_\_Yes \_\_\_\_No

(1) If yes, please provide the following:

Name of Company: \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
(Street) (Area Code) (Number)

\_\_\_\_\_  
(City) (State) (Zip Code)

L. Have you ever smoked cigarettes, cigars, pipe or other tobacco products? \_\_\_\_Yes \_\_\_\_No

If yes, have you quit? \_\_\_\_Yes \_\_\_\_No If yes, how long? \_\_\_\_\_

**PART III PREMIUM** (Refer to the Premium Rate Table for the amount due)

Please make sure that you have the correct plan (A, B, C, or D) and that you have checked the appropriate age, sex, geographic region and smoker/non-smoker status. If your zip code begins with the numbers 700 or 701 you will utilize the New Orleans rates. If your zip code begins with 707, 708, 710, or 711 you will utilize the Baton Rouge/Shreveport rates. If your zip code is not included is those described, please use the rates for "Other".

A. Initial Premium amount enclosed in the amount of \$\_\_\_\_\_. Please make check payable to Louisiana Health Plan.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## PART IV MEDICAL QUESTIONS

You must fill out all of these medical questions or your application will not be processed. (If you have any questions about filling out this information, please contact your doctor's office.)

### HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING

	YES	NO
01. Asthma or other bronchial condition	_____	_____
02. Emphysema, tuberculosis or lung disorder	_____	_____
03. Cancer, Leukemia or Hodgkins disease (including malignant brain tumors)	_____	_____
04. Benign tumors, cysts and polyps	_____	_____
05. Colitis or intestinal disorder	_____	_____
06. Gall bladder disease or gall stones	_____	_____
07. Ulcers or other stomach or esophagus disorders	_____	_____
08. Chronic renal failure or polycystic-kidney disease	_____	_____
09. Other urinary system disorder (including other kidney disease/stones)	_____	_____
10. Stroke or paralysis	_____	_____
11. High blood pressure (indicate latest reading) _____/_____ (Systolic/Diastolic)	_____	_____
12. Third degree burns	_____	_____
13. Heart attack, heart disease or angina	_____	_____
14. Other disorders of the heart or circulatory system	_____	_____
15. Diabetes (indicate latest blood sugar level) _____/_____ (mg/dl)	_____	_____
16. Thyroid disorder or goiter	_____	_____
17. Chronic hepatitis	_____	_____
18. Other liver disorder (including cirrhosis)	_____	_____
19. Disorder of the spleen or pancreas	_____	_____
20. Seizure disorder	_____	_____
21. Multiple Sclerosis, Muscular dystrophy or other neuromuscular condition	_____	_____

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

**MEDICAL QUESTIONS CONTINUED**

- |   | <b>YES</b> | <b>NO</b> |
|---|------------|-----------|
| 22. Disorder of the brain or nervous system   | _____      | _____     |
| 23. Acute Leukemia  | _____      | _____     |
| 24. Other disorder of the blood/Anemia  | _____      | _____     |
| 25. Lupus   | _____      | _____     |
| 26. Disorders of spine, or discs  | _____      | _____     |
| 27. Disorders of joints or bones including arthritis  | _____      | _____     |
| 28. Disorders of the reproductive system  | _____      | _____     |
| 29. Sexually transmitted disease  | _____      | _____     |
| 30. Congenital (birth) diseases or defects  | _____      | _____     |
| 31. AIDS, AIDS-Related Complex, or Disorder of Immune System (including HIV Positive results) | _____      | _____     |
| 32. Other _____   | _____      | _____     |
| 33. Are you taking prescription drugs to lower your cholesterol?                              |            |           |
| 34. What is your height (without shoes)? _____ ft. _____ in.                                  |            |           |
| 35. What is your weight (without clothes)? _____ lbs.   |            |           |

Refer to Part VIII for "YES" answers

**PART V PHYSICIAN INFORMATION**

(1) Please provide the names, addresses, and telephone numbers of all physicians who are presently treating you, or who have treated you in the last 5 years. **Please sign and date any additional information which must be attached to this application.**

Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
(Street) (Area Code) (Number)

\_\_\_\_\_  
(City) (State) (Zip Code)

Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
(Street) (Area Code) (Number)

\_\_\_\_\_  
(City) (State) (Zip Code)

\_\_\_\_\_  
Date Signature

Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
(Street) (Area Code) (Number)

\_\_\_\_\_  
(City) (State) (Zip Code)

Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
(Street) (Area Code) (Number)

\_\_\_\_\_  
(City) (State) (Zip Code)

**PART VI PRESCRIPTION INFORMATION**

- (1) Have you taken prescribed medications within the last year? \_\_\_\_Yes \_\_\_\_No
- (2) If yes, please complete the following: Please sign and date any additional information which must be attached to this application.

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician if NOT already provided: \_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician if NOT already provided: \_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician if NOT already provided: \_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician if NOT already provided: \_\_\_\_\_  
\_\_\_\_\_

Name of Medicine \_\_\_\_\_ Dosage \_\_\_\_\_  
Reason \_\_\_\_\_ Prescribing Doctor \_\_\_\_\_  
Address and telephone of prescribing physician if NOT already provided: \_\_\_\_\_  
\_\_\_\_\_

**PART VII RELEASE OF INFORMATION AND AUTHORIZATION**

I authorize any insurance company, organization, employer, or provider of services to release any information related to my medical condition for eligibility determination and for future claims submitted to the Louisiana Health Plan for payment.

\_\_\_\_\_  
Signature of Applicant or Signature of Parent or Legal Guardian  
(if the applicant is under age 18, or legally incompetent)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**PART VIII MEDICAL QUESTIONS CONTINUED**

For each question answered "YES" on "Medical Questions in Section IV," please answer the questions below. If you have answered "yes" to more than 2 questions, please make additional copies of this sheet before proceeding.

1. Question Number	# _____	# _____
2. When did this condition first occur?	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____
3a. Is ongoing treatment for this condition being provided?	Yes _____ No _____	Yes _____ No _____
3b. If not, when did the last treatment occur?	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____
3c. If not, has treatment been recommended for this condition?	Yes _____ No _____	Yes _____ No _____
4a. Did the condition result in hospitalization?	Yes _____ No _____	Yes _____ No _____
4b. If yes, when did this occur?	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____	Less than 1 year ago _____ 1-3 years ago _____ 3-5 years ago _____ More than 5 years ago _____
4c. If yes, duration of hospital stay?	Less than 5 days _____ 5-10 days _____ More than 10 days _____	Less than 5 days _____ 5-10 days _____ More than 10 days _____
4d. If yes, was surgery performed?	Yes _____ No _____	Yes _____ No _____

\_\_\_\_\_ Date

\_\_\_\_\_ Signature



# LOUISIANA HEALTH PLAN

P. O. Drawer 83880

Baton Rouge, Louisiana 70884-3880

(225) 926-6245 Fax (225) 927-3873

## PREMIUM PAYMENTS

1. Premium payments can ONLY be made by personal check. **All payments must be by personal check drawn on the account of the policyholder. *No business or other “third party” checks OF ANY KIND will be accepted. The only exceptions to this policy are:*
  - LHP will accept the personal check drawn on the account of **the policyholder’s parent or legal guardian.**
  - LHP will accept the check drawn on a **trust account** established individually for the policyholder (no group, government or class trusts).
  - LHP will accept **money orders or certified funds** *only after the policyholder has contacted LHP and signed a statement attesting to the source of the funds.* To obtain an affidavit, contact Brandon J. Billeaudeau at 1-800-736-0947, Extension 103 or in Baton Rouge 926-6245, Extension 103. E-mail: [bbilleaudeau@lahealthplan.org](mailto:bbilleaudeau@lahealthplan.org)
  - **No cash** is ever accepted.**
2. **Premium payments will be deposited immediately upon receipt.** We will not “hold” checks. Please make sure that your account has sufficient funds for payment. All NSF checks will be posted as “non-payment” of premium.

# LOUISIANA HEALTH PLAN

P. O. Drawer 83880

Baton Rouge, Louisiana 70884-3880

(225) 926-6245 Fax (225) 927-3873

## DEDUCTIBLE PROCEDURE

**Before you select your deductible for the year, please note that at renewal time in December each year (and for the lifetime of your policy) you will ONLY BE ALLOWED TO SELECT THE SAME OR HIGHER DEDUCTIBLE.** Therefore, if you select a \$2,000 deductible this year, you will only be allowed to remain at the \$2,000 deductible or select a \$3,500 or \$5,000 in the future. If you select a \$5,000 deductible, you will not be allowed to change to a lower deductible.

The Out-of-Pocket Maximums are:

Deductible Amount	Maximum out-of-pocket Expense for each Covered Person INCLUDING THE DEDUCTIBLE	
\$1,000	\$4,500	(\$1,000 Deductible + \$3,500)
\$2,000	\$6,500	(\$2,000 Deductible + \$4,500)
\$3,500	\$8,000	(\$3,500 Deductible + \$4,500)
\$5,000	\$9,500	(\$5,000 Deductible + \$4,500)

**Please sign, date and return:**

Yes, I have read the statement above and understand that in the year 2003 and thereafter, I will only be able to select the same or higher deductible.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**LOUISIANA HEALTH PLAN**  
**P. O. Drawer 83880**  
**Baton Rouge, Louisiana 70884-3880**  
**(225) 926-6245 800-736-0947 Fax (225) 927-3873**

**INCOME QUESTIONNAIRE**

Please complete the following questionnaire and return it with the enclosed forms.

If your family income is equal to, or less than, the figures in the chart, Louisiana Health Plan may contact you. Further information may be required.

I, \_\_\_\_\_, have reviewed the family income schedule below.  
 (please print your name)

**Income Amounts through March 31, 2006**

Number in Family	*Gross Weekly Income	Gross Monthly Income
1	\$388	\$1,552
2	\$520.50	\$2,082
3	\$653	\$2,612
4	\$785.50	\$3,142
5	\$918	\$3,672
6	\$1,050.50	\$4,202
7	\$1,183	\$4,732
8	\$1,315.50	\$5,262
More than 8	For each extra person, add \$530 to the monthly amount for 8 people	

\*Gross Income is your income without any deductions  
 Please note that no exact dollar figure is required at this time

My family income:

- is EQUAL to, or LESS than, the schedule above
- is GREATER than the schedule above

Please check all that apply:

- I have a spouse
- I have a child aged 18 or younger living in my house. If yes, how many children ages 18 or younger live in your house? \_\_\_\_\_
- I have a disabled dependent child older than 18 years living with me

\_\_\_\_\_  
 Signature of Policyholder

\_\_\_\_\_  
 Date

Or

Signature of Parent or Legal Guardian if the Policyholder is  
 Under 18 years of age, interdicted or a full-time student at an out-of-  
 State tuition at the non-Louisiana educational facility

**Louisiana Health Plan**  
**P. O. Drawer 83880**  
**Baton Rouge, LA 70884-3880**  
**(225) 926-6245    1-800-736-0947    FAX (225) 927-3873**

**Before mailing your application, please be sure that you have:**

- Signed each page of the application and medical questions where indicated**
  
- Enclosed a photocopy of the front and back of your drivers license or other proof of residency**
  
- Signed Deductible Procedure Form**
  
- Completed and Signed the Income Questionnaire**
  
- Enclosed a check in the exact amount for the first month's premium made payable to: "Louisiana Health Plan"**