



APPLICATION FOR COVERAGE

SECTION 1

PLEASE PRINT OR TYPE

Last Name:		First Name:		M.I.:	Social Security Number:
Mailing Address:		City:	State:	Zip Code:	Home Telephone No.:
Address where you reside:		City:	State:	Zip Code:	Work Telephone No.:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:		Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Minor Child (under age 18)		

SECTION 2

1. Check One: New Applicant Transfer from another state's health risk pool – Which state? _____

2. Deductible Choice: \$1,000 Medical \$2,000 Medical \$3,000 Medical \$5,000 Medical \$10,000 Medical
 \$250 Pharmacy \$500 Pharmacy \$500 Pharmacy \$750 Pharmacy \$1000 Pharmacy

The deductible that you choose cannot be lowered in the future.

3. Method of Payment: Monthly Bank Draft Annual Bank Draft Annual Direct Billing

4. Who will make your premium payment? Self Employer Other
If "other" give name, relationship to applicant and details: _____

5. Will you be reimbursed for your premiums by any individual or organization? Yes No
If "yes", give details: _____

6. Will any individual or organization pay or reimburse you for a portion of your premium, or will any individual or organization pay or reimburse you for your deductibles and/or co-pays? Yes No
If "yes", give details: _____

SECTION 3

1. Are you a citizen of the United States of America? Yes No; If "no", please explain: _____
_____ and attach a copy of form I-151 or I-551 (Green Card).

2. Are you a legal resident of the State of Mississippi? Yes No

3. Have you been a Mississippi resident for six (6) consecutive months prior to application? Yes No
This requirement may be waived for applicants who have been legal residents of the State of Mississippi for less than six months but who have been covered by another state's health risk pool and shall not apply to applicants who are eligible under the Health Insurance Portability and Accountability Act of 1996. ("HIPAA")
IMPORTANT: PROOF OF RESIDENCY MUST BE ATTACHED IN THE FORM OF A COPY OF CAR TAG RECEIPT, VOTER REGISTRATION CARD, DRIVER'S LICENSE, ETC.

4. Are you a resident or inmate of a public institution? Yes No
If "yes", name institution and provide details: _____

5. Do you have, or are you eligible to receive, Medicaid benefits? Yes No
If "yes", give details including effective date of coverage: _____

6. Have you been covered by the Association at any time during the past twelve (12) months? Yes No

7. Do you have, or are you eligible to receive, Medicare benefits? Yes No
If "yes", give details including effective date of coverage: _____

8. Are you currently receiving health care benefits under any Federal or State program providing financial assistance and/or preventative and rehabilitative social services? (Examples: Children's Medical Program, Veterans Administration) Yes No

If "yes", explain and give effective date of benefits: _____

9. Are you currently receiving benefits under Workers Compensation? Yes No

If "yes", give details: _____

10. Have you received, or do you expect to receive, a legal settlement that will pay any of your medical expenses? Yes No

If "yes", give details: _____

11. Are you currently covered, or have you within the past 63 days been covered by any type of medical insurance contract or policy including, but not limited to, group coverage through an employer, an individual major medical policy, an accident only policy, a hospital daily indemnity policy or a cancer policy? Yes No; If "yes", give details: _____

12. If the answer to question #11 is yes, please indicate the type of policy:

Employer/Group Coverage Individual (Non-Group) Coverage

13. Have you applied for health coverage elsewhere, and is the application still pending? Yes No

If "yes", please give details: _____

14. If you are accepted for Association coverage, do you plan to retain your other coverage while serving your pre-existing condition exclusionary period required by the Association coverage? Yes No Not Applicable

15. If your answer to question #14 is "Yes", please indicate the date your other coverage will end? _____

[Note: You are not eligible to maintain Association coverage and other similar coverage, except while satisfying the preexisting condition exclusionary period.]

16. Are you currently employed? Yes No; If "yes" please furnish name, address, and telephone number of employer: _____

17. If employed, is medical coverage available at your place of employment? Yes No

If "yes", do you qualify for coverage? Yes No

If you do not qualify for coverage, please explain in detail: _____

18. If you qualify for coverage, at your place of employment, have you applied for coverage? Yes No Not Applicable

If "no", why have you not applied for coverage? Please explain in detail: _____

19. Is your spouse (or parent, if applicant is minor) currently employed? Yes No Not Applicable

If "yes", please furnish name, address and telephone number of employer: _____

20. If employed, is medical coverage available at his/her place of employment? Yes No Not Applicable

If "yes", do you qualify for coverage? Yes No

If "no", why do you not qualify for coverage? Please explain in detail: _____

21. If you qualify for coverage through your spouse's or parent's place of employment, have you applied for coverage?

Yes No Not Applicable; If "no", why have you not applied for coverage? Please explain in detail: _____

22. Have you ever received any benefits from the Association or any similar organization in another state? Yes No

If "yes", please give details: _____

23. List any pre-existing medical conditions: _____

Height: _____ Weight: _____

COMPLETE ONLY ONE OF THE FOLLOWING:

(Not necessary if HIPAA eligible)

24. During the 12 months prior to applying for Association coverage, because of health reasons, have you been rejected or refused by a licensed insurance company, nonprofit health care services plan or HMO for coverage substantially similar to Association coverage; or have you been offered coverage with material underwriting restrictions or offered coverage at a rate exceeding the Association's plan rate? Yes No

Name Company and date of refusal: _____

State reason for refusal: _____

If you completed question #24, **DO NOT** complete question #25.

25. Do you have one or more of the conditions on the automatic rejection list (see agent for list)? Yes No

Please indicate condition(s): _____

APPLICANT'S STATEMENT

BE SURE TO READ CAREFULLY

I hereby apply for coverage under a policy issued by the Mississippi Comprehensive Health Insurance Risk Pool Association. I request coverage in accordance with and subject to the conditions and limitations set forth in the Mississippi Comprehensive Health Insurance Risk Pool Association Act, the Amended and Restated Articles, Bylaws and Operating Rules of the Association, and in accordance with the terms and provisions of the policy offered by the Association. If applicant is a minor or otherwise incompetent to make the certifications set forth below, I hereby make such certifications and represent that I am authorized to do so.

1. I certify that the statements and answers in this application are complete and true to the best of my knowledge and belief.
2. I understand that no insurance coverage will become effective until the first day of the month following approval of this application by the Association unless the Association determines that the applicant qualifies for a different policy effective date.
3. I understand that the preexisting condition exclusionary period under any policy issued by the Association shall be twelve months, the benefit waiting period for pregnancy-related benefits shall be nine months and the benefit waiting period for all pharmacy benefits shall be 180 days, unless I complete the Request to Waive Preexisting Condition Exclusionary and Waiting Periods (page 5) and the Association determines that the applicant qualifies for shortened preexisting condition exclusionary and waiting periods.
4. I agree that grievances and appeals shall be handled in accordance with Article XV of the Amended and Restated Articles, Bylaws and Operating Rules of the Association, a copy of which may be obtained upon written request to the Association.
5. I understand that no agent or broker may alter the terms of this application or the policy of insurance or waive any of the Association's rights or requirements.
6. I understand that a policy issued by the Association may be cancelled by the Association at any time a policyholder becomes ineligible for coverage or for failure to respond to any Association inquiry concerning eligibility.
7. I certify that applicant is not eligible for any type of major medical insurance contract or policy other than coverage allowed while serving a pre-existing condition exclusionary period, and that applicant has no medical coverage or benefits other than those disclosed herein.
8. If the Association issues a policy to applicant, I agree to notify the Association immediately if applicant becomes eligible for other coverage or otherwise becomes ineligible for the Association's coverage.
9. I authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau, employer or other organization, institution or person that has any records or knowledge of applicant to give to the Association or the Administering Insurer any such information. A photographic copy of this authorization shall be valid as the original.

Signature of Proposed Insured (Parent or Guardian, if Minor)	Date Signed (Month, Day, Year):	City:	State:	Zip Code:
Witnessed by:	Date:			

If the applicant has lost existing medical insurance coverage during the past 63 days, through no fault of his/her own, see page 5 to determine if applicant qualifies for waiver of preexisting condition exclusionary and waiting periods.

IMPORTANT NOTICE ABOUT THE POLICY OF INSURANCE FOR WHICH YOU HAVE APPLIED

THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS

READ THE FOLLOWING INFORMATION CAREFULLY.

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any dispute related to this policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the Comprehensive Health Insurance Risk Pool Association.
4. In an arbitration, one or more arbitrators, who are independent, neutral decision makers, render a decision after hearing the positions of the parties.
5. When you accept this insurance policy you agree to resolve any dispute related to the policy by binding arbitration instead of a trial in court, including a trial by jury.
6. Binding arbitration generally takes the place of resolving disputes by a judge and jury.
7. Should you need additional information regarding the binding arbitration provision in the policy, you may contact our toll free assistance line at 1-888-820-9400.

ACKNOWLEDGEMENT OF ARBITRATION AGREEMENT

I have read this statement. I understand that I am voluntarily surrendering my right to have any dispute between the Comprehensive Health Insurance Risk Pool Association and myself resolved in court. This means I am waiving my right to trial by jury.

I understand that upon receipt of the policy, I should read the arbitration clause contained in the policy and that I have the right to reject this policy within ten (10) days of the date of delivery if I do not want to accept the requirement for arbitration.

I understand that this same type of insurance may be available through an insurance company that does not require that policy related disputes be resolved by binding arbitration.

Applicant/Insured

Date

Time

Agent or Witness

Date

Time

REQUEST TO WAIVE PREEXISTING CONDITION EXCLUSIONARY AND WAITING PERIODS.

DO NOT COMPLETE THIS PAGE UNLESS YOU QUALIFY!

(See below for qualification and documentation.)

IF YOU COMPLETE THIS PAGE AND QUALIFY, YOU ARE REQUIRED TO PAY THE PREMIUM RATE FOR IMMEDIATE COVERAGE.

IF YOU COMPLETE THIS PAGE AND DO NOT QUALIFY FOR SHORTENED PREEXISTING CONDITION EXCLUSIONARY AND WAITING PERIODS, BUT OTHERWISE QUALIFY FOR ASSOCIATION COVERAGE, THIS PAGE SHALL BE NULL AND VOID, AND YOUR COVERAGE WILL CONTAIN PREEXISTING CONDITION AND WAITING PERIODS.

SUPPLEMENT TO APPLICATION FOR COVERAGE

If you are accepted for Association coverage, you may be eligible to have the preexisting condition exclusionary and waiting periods waived.

TO QUALIFY:

1. You must have been covered by (a) group medical insurance through an employer-based plan or (b) individual health insurance that was written by an insurer licensed to transact insurance in Mississippi and which was terminated due to the insurer's withdrawal from the state, discontinuance of a market, liquidation, rehabilitation, conservation, etc.
2. You must have accepted any extension of benefits available to you when your group insurance coverage ended, such as COBRA or state continuation coverage ("mini-COBRA"), and you must have maintained such extension of benefits until they expired;
3. You must not have lost your most recent coverage through non-payment of premium or fraud;
4. You must not be eligible for Medicare or Medicaid;
5. You must not be eligible for employer based health insurance coverage; and
6. At the time your most recent coverage ended, you must have been covered continuously for eighteen or more months without a significant break in coverage. A significant break in coverage is a period greater than 63 days.

REQUIRED DOCUMENTATION:

1. If you have COBRA or state continuation of coverage ("mini-COBRA") that is ending, you must provide a copy of the election form that was completed when you requested continuation of your group coverage. This form documents the beginning date of continuation coverage and the term of such coverage (12, 18, 29 or 36 months). If you do not have a copy of this document, you should contact your prior employer or insurer to get a copy. (A letter from your employer may be substituted.)
2. If COBRA or state continuation of coverage ("mini-COBRA") is not available, documentation must be furnished as to why it is not available and as to why your group coverage is ending.
3. A copy of the "Certificate(s) of Group Health Plan Coverage" (HIPAA certificate) or certificate of coverage from prior 18 months of coverage. If you lost individual health insurance, a copy of the "Certificate(s) of Individual Health Insurance Coverage" should be furnished. Other appropriate documentation may be substituted.
4. If individual insurance coverage has been lost due to insurance company insolvency, withdrawal from Mississippi or discontinuance of policies within the state, furnish a copy of the termination letter received from the insurance company.

NOTE: A retroactive effective date may be assigned provided all required documentation and premium payments are submitted within 63 days of the loss of coverage event.

Name of Applicant - Last:	First :	M.I.:	Social Security Number:	Date of Termination of Coverage: (Month, Day, Year)
Name of Employer:			Name of Insurance Carrier:	
Policy Number:			Certificate Number:	
Signature of Proposed Insured: (Parent or Guardian, if Minor)			Date Signed: (Month, Day, Year)	
Witness:			Date:	

AGENT'S CERTIFYING STATEMENT

- 1. Are you an agent licensed to sell health insurance in the State of Mississippi? Yes No
- 2. Did you see the proposed insured? Yes No
- 3. Are you aware of any information, which might disqualify the proposed insured from being eligible for Association coverage?
 Yes No If "yes", please explain: _____
- 4. To your knowledge, is the policy applied for herein intended to replace any existing insurance coverage? Yes No
If "yes", please explain _____

I understand that it shall constitute an unfair trade practice for any insurer, insurance agent or broker, or employer, or third party administrator to refer an individual employee or a dependent of an individual employee to the Association, or to arrange for an individual employee or a dependent of an individual employee to apply to the program, for the purpose of separating such employee or dependent from a group health benefits plan provided in connection with the employee's employment and I certify that I have accurately recorded on the application the information supplied by the proposed insured.

Agent's Signature:		Date:	Phone No.:	
Agent Name:		Mississippi Agent License No.:	Agent Social Security Number:	
Agent Mailing Address:		City:	State:	Zip Code:

AGENT CHECKLIST

- The Application for Coverage must be completed in full with details provided as requested.
- The Application for Coverage must be signed, dated and witnessed.
- The Agent's Certifying Statement must be completed and signed. The agent's mailing address and Insurance License Number must be included.
- Premiums must be paid by automatic bank deduction or paid annually via direct billing. Annual payments may also be paid via automatic bank deduction. The Authorization Agreement on Page 8 must be completed. A voided check must also be included if the bank draft option is selected.
- IF THE ANNUAL PAYMENT DIRECT BILLING OPTION IS CHOSEN, A CHECK OR MONEY ORDER FOR THE INITIAL PREMIUM MUST ACCOMPANY THIS APPLICATION. THE CHECK OR MONEY ORDER MUST BE MADE PAYABLE TO MISSISSIPPI COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION. DO NOT SEND A CHECK WITH THIS APPLICATION UNLESS APPLICANT SELECTS THE ANNUAL DIRECT PREMIUM OPTION.**
- THE APPLICATION (AND ANNUAL PREMIUM REMITTANCE IF THE ANNUAL DIRECT BILLING OPTION IS CHOSEN) SHOULD BE FORWARDED TO:**

**BLUE CROSS & BLUE SHIELD OF MISSISSIPPI
ENROLLMENT CONTROL CENTER - MS COMPREHENSIVE HEALTH INSURANCE RISK POOL
ASSOCIATION
P O BOX 1043
JACKSON, MS 39215-1043**

THE AUTHORIZATION ON PAGE 8 MUST BE COMPLETED IF YOU CHOOSE THE BANK DRAFT OPTION

CALCULATION OF PREMIUMS

The premium rate is based on the applicant's age as of his or her last birthday. The rates shown in the descriptive brochure are one twelfth of the annual premium. Premiums increase each year as a policyholder gets older. Additionally, premium rates may increase from time to time based upon the claims experience of the plan.

There are three premium modes available under the Association plan — Monthly Bank Draft, Annual Bank Draft and direct Annual Billing.

Annual Direct Billing Mode – calculate the annual premium by multiplying the rate shown in the descriptive brochure by twelve. The applicant must furnish a check or money order payable to the Association for the full amount of the annual premium. If the effective date is any date other than the 1st of the month, applicant must pay the pro-rated premium for that month plus premium for a full year (12 x monthly premium).

Annual Bank Draft Premium Mode – calculate the annual premium by multiplying the rate shown in the descriptive brochure by twelve. The applicant's bank account will be drafted by the Association approximately 10 days after the notification of the initial bank draft amount is sent by the Association to the applicant. Applicant can choose the 1st or 6th as the date in the month that the annual draft will occur.

Monthly Bank Draft Mode – The premiums shown in the descriptive brochure are the monthly bank draft rates. However, some banks charge a fee for processing drafts. If the applicant's bank charges a fee for processing his or her draft, the amount of that fee will be added to the monthly premium amount drafted by the Association. The applicant's bank account will be drafted by the Association approximately 10 days after notification of the initial bank draft amount is sent by the Association to the applicant. Applicant can choose the 1st or 6th as the date that the monthly draft will occur.

If an applicant elects the Monthly or Annual Bank Draft Mode of payment:

1. Complete the Authorization Agreement for Pre-arranged Payment on page 8.
2. Furnish a blank voided check on the bank account that is to be drafted.

Prorated Month – An applicant who qualifies for reduced pre-existing condition exclusionary and waiting periods can begin Risk Pool coverage on the day after the loss of coverage event. If the effective date will be a date other than the first, the premium is calculated by dividing the monthly rate by 30 and multiplying by the number of days left in the month to be insured.

SEE PAGE 7 FOR INSTRUCTIONS

AUTHORIZATION AGREEMENT FOR PRE-ARRANGED PAYMENTS			
Name of Applicant for Insurance:		Please draft my account: <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	
Name of Premium Payor:			
Payor's Social Security Number or Tax ID Number:	Name on Payor's Bank Account:	Please draft my account on: <input type="checkbox"/> 1st day <input type="checkbox"/> 6th day SEE NOTE BELOW	
Payor's Address:		City:	State: Zip Code:
Bank or Branch Name:	Bank's Address:	Checking Account Number:	
<p>I hereby authorize the Association's Administering Insurer, Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, to initiate entries to my financial institution account indicated below and the financial institution indicated below to debit this same account. This authority remains in full force and effect until the Association or Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company receives my written notification of its termination in such time and manner as to afford Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company and the financial institution a reasonable time to act on it. Also, the Association or its Administering Insurer, Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, may cancel my automatic withdrawal by notification of such cancellation in writing. I understand that this authorization is effective on the date of my execution of same below and that Blue Cross & Blue Shield of Mississippi will immediately process the Automatic Withdrawal Application on that date. In that connection, I further understand that should I be approved for the coverage sought by my completion and submittal of this application, that the initial premium will be withdrawn by debit to the financial institution account indicated below. Before this initial debit is made to the financial institution account indicated below, I understand that Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company will provide me ten (10) days written notification (from notification mail date) of the amount and anticipated date of the debit. I understand that thereafter debits will continue without further notice to me.</p>			
Date:	Payor's Customer Signature (as accepted by Bank):		
<p>This authority is to remain in full force and effect until the Mississippi Comprehensive Health Insurance Risk Pool Association and Depository have received written notification from me of its termination in such time and in such manner as to afford the Mississippi Comprehensive Health Insurance Risk Pool Association and Depository opportunity to act on it.</p>			
<p>NOTE: If a bank draft date is not selected, a "1st Day" draft date will be assigned.</p>			

MISSISSIPPI COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION

FOR OFFICE USE ONLY

Date Received _____ Eff. Date _____ Deductible: \$1,000 \$2,000 \$3,000
 \$5,000 \$10,000

Premium Submitted \$ _____ Annual Agent Code _____

Group # _____ Contract _____ Preexisting Condition Term 0 12

Approve Date _____ Pended _____ Void Date _____ By _____

Lifetime Max _____ COB _____ Process Date _____ By _____