# Nebraska Comprehensive Health Insurance Pool

Administered by Blue Cross and Blue Shield of Nebraska, a Mutual Insurance Company and Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 3248 Omaha, Nebraska 68180-0001 343-3574 (Omaha Area) 1-877-348-4304 (Toll Free)

## APPLICATION FOR COVERAGE

| Social Security Number | Name: (Last, First, Middle Initial, Title) | Date of Birth (Month, Day, Year) | ☐ Male ☐ Female |
|---|---|---|---|

Address: Street and/or P.O. Box | City | State | Zip Code+4 | County | Length of time at present address:

**PLAN ELECTION** **Please Note:** Only changes to a higher deductible are allowed.

Calendar Year Deductible Options PPO/Non-PPO:

☐ $500/$1,000 ☐ $1,000/$2,000 ☐ $1,500/$3,000 ☐ $2,000/$4,000 ☐ $3,000/$6,000
☐ $4,000/$8,000 ☐ $5,000/$10,000 ☐ $7,500/$15,000 ☐ $10,000/$20,000 ☐ HSA – HDHP $2,000/$4,000

**Maternity Endorsement** ☐ Yes ☐ No
**Are you a tobacco user?** ☐ Yes ☐ No If no, read and sign the box below:

**NON-TOBACCO USER CERTIFICATION STATEMENT**

I certify that I neither presently smoke or use tobacco products, nor have I smoked or used tobacco products (regardless of frequency) during the 12 months immediately preceding the date of this application. I understand that if my application is accepted, I will be entitled to a non-tobacco user discounted premium rate, and the Administrator will rely upon my application in determining my appropriate premium rate. **I understand that any misrepresentation of the information contained on this certification could result in denial of future claims or back payment of the tobacco-user premium rate from the effective date of CHIP coverage.**

Signature of Applicant ______________________ Date ______________

**Requested Policy Effective Date (choose one):**

1. ☐ First of the month following receipt of application by Administrator.
2. ☐ Date of receipt of application by Administrator (one month premium plus partial month premium will be needed).
3. ☐ A date later than 1 or 2, above: ______________
   Month Day Year

Exception: If you qualify for Pre-existing Condition waiver 2 or 3 (see next page), your effective date will be the date following termination of prior coverage.

**Premium Payment Method:** ☐ Monthly Direct Bill ☐ Monthly Bank Debit
If Monthly Bank Debit is selected, please complete the following Debit Authorization section:

**DEBIT AUTHORIZATION -** I authorize Blue Cross and Blue Shield of Nebraska to initiate debit entries (charges) to my account indicated below and the Financial Institution named below to charge the said account.

| Financial Institution | Town/City | Account Number ☐ Checking ☐ Savings |
|---|---|---|

This authority is to remain in full force and effect until the Financial Institution has received written notification from me of its termination in such time as to afford the Financial Institution a reasonable opportunity to act on it. The initial authorization is for $__________ to be charged to my account on or after the 15th day of each month. Such amount may be changed from time to time by Blue Cross and Blue Shield of Nebraska giving me written notice before changing said amount. **ATTACH A VOIDED CHECK FOR OUR RECORDS**.

A. Are you covered by or eligible for Medicaid? ☐ Yes ☐ No
   **If you are eligible for Medicaid, you are not eligible for CHIP.**
B. Have you been covered by Medicaid during the past 12 months? ☐ Yes ☐ No If yes, when ______________
C. Are you covered by or eligible for Medicare? ☐ Yes ☐ No
   If yes, did you qualify by reason of turning age 65, or for other reasons? ☐ Age 65 ☐ Other
   Please attach a copy of your Medicare card and Medicare's notice of eligibility.
   **If you are eligible for Medicare based on age, you are not eligible for CHIP.**
D. For females only: Do you have reason to believe you may now be pregnant? ☐ Yes ☐ No
E. Do you have other insurance coverage? ☐ Yes ☐ No Name of Company ______________
F. Is the above coverage through an employer? ☐ Yes ☐ No
   If yes, state name of employer ______________
G. Does your employer or the employer of your spouse or parent offer group health insurance coverage? ☐ Yes ☐ No
   If yes, state name of insurance company ______________
   **Please Note: CHIP benefits shall be reduced by all amounts payable under any other health insurance or coverage**

## ELIGIBILITY CERTIFICATION #1: I certify that I am eligible for CHIP coverage as follows:

I have been a legal resident of Nebraska for at least six months, **and** (check ONE which applies to you):

- ☐ I have been rejected for other health insurance coverage due to reasons of health within the past six months. **(Attach a copy of the rejection letter.)**
- ☐ I currently have, or was offered within the past six months, other health insurance coverage which includes a restrictive rider due to reasons of health. **(Attach proof of having or being offered such restrictive rider.)**
- ☐ I have been offered health insurance coverage similar to this program, but at higher rates within the past six months. **(Attach a copy of the insurance offer showing higher rates. Include a copy of the Schedule of Benefits.)**
- ☐ I am eligible for the CHIP coverage because of my health condition of: ______________________________
  ______________________________________________________________

### PRE-EXISTING CONDITIONS:

The CHIP policy excludes coverage of pre-existing conditions for a period of six months, unless you qualify for one of the pre-existing condition waivers described below. **I apply for a Pre-existing Condition Waiver as follows:**

☐ **Pre-existing waiver #1 -** Prior Medicaid, Medically Handicapped Children's Program, Medicare.
This waiver is available if during the six-month period immediately preceding the effective date of CHIP coverage: 1) you have received medical assistance through Medicaid or the Medically Handicapped Children's Program; or 2) you are an organ transplant recipient terminated from Medicare.
**Please attach copy of appropriate document(s) to verify eligibility for this pre-existing condition waiver.**

☐ **Pre-existing waiver #2 -** Involuntary Termination of Prior Coverage within the past 60 days.
My prior coverage terminated (date: ______________) due to: (check appropriate box)

1) ☐ the withdrawal by the insurer from this state
2) ☐ the bankruptcy or insolvency of my employer or employer trust fund
3) ☐ the cessation by my employer of providing any group health plan for all of its employees.

I certify that I am not eligible for any conversion policy or continuation of coverage policy. If you qualify for this waiver, the CHIP effective date shall be the date following the termination of prior coverage, and you are responsible for paying premium from that effective date. The CHIP pre-existing condition exclusion will be waived only to the extent that any similar exclusion was satisfied under your prior coverage.
**Please attach a letter of verification from either your employer or prior insurance carrier to document your eligibility.**

☐ **Pre-existing waiver #3 -** Termination or involuntary termination of a continuation of coverage policy available under state or federal law within the past 90 days**. Please attach a letter or other documentation from the employer or insurance carrier which indicates the termination date of COBRA or other such continuation of coverage policy.**
If you qualify for this waiver, the CHIP effective date shall be the date following the termination, and you are responsible for paying premium from that effective date. The CHIP pre-existing condition exclusion will be waived only to the extent that any similar exclusion was satisfied under your prior coverage.

## ELIGIBILITY CERTIFICATION #2: I certify that I am eligible for CHIP coverage as follows:

☐ I am a legal Nebraska resident and meet all of the following requirements:

1) have an aggregate of at least 18 months of prior creditable coverage*, most recently under an employee group health plan, governmental or church plan;
2) am not eligible for a group health plan, Medicare or Medicaid;
3) do not have other health insurance; and
4) am not eligible for, or have exhausted continuation coverage under COBRA or similar law; or I have been offered continuation coverage under COBRA or a similar program at a premium higher than that available from the Pool.

*Creditable coverage does not include any coverage that occurs before a significant break in coverage. A significant break in coverage is any period of 63 days during which you did not have any creditable coverage.

**Attach certificate(s) of prior creditable coverage and COBRA documentation.**

### PRE-EXISTING CONDITIONS

The CHIP policy excludes coverage of pre-existing conditions for a period of six months. If you are eligible for CHIP pursuant to this Eligibility Certification #2, this pre-existing condition waiting period will be waived.

## ELIGIBILITY CERTIFICATION #3: I certify that I am eligible for CHIP coverage as follows

☐ I am a legal Nebraska resident and potentially eligible for the Health Coverage Tax Credit (HCTC) under the Trade Adjustment Assistance Reform Act of 2002. **Complete Attachment A.**

### PRE-EXISTING CONDITIONS

The CHIP policy excludes coverage of pre-existing conditions for a period of six months. If you are eligible for CHIP coverage as a qualified trade adjustment assistance eligible individual, and have an aggregate of at least 3 months of creditable coverage as of the date of this application (without a significant break of more than 62 days), this pre-existing condition waiting period will be waived.

**Premium payments are required on a monthly basis due on the first of each month. A check for the first monthly premium must be attached to this application. Also attach proof of Nebraska residency. For example, rent receipts, state income tax return, house payment records, employment records, driver's license, etc.**

I represent that my answers and statements on this application are true and complete to the best of my knowledge. I authorize my health care providers to furnish the CHIP Administrator with medical information to the extent necessary for processing claims. I understand that I must be, and remain a Nebraska resident to be eligible for CHIP coverage.

Applicant Signature ______________________________ Date ______________________

Applicant Phone Number ______________________________

***AGENT USE ONLY*** (***Please Print***) *I represent that the answers and statements on this application are true and complete to the best of my knowledge.*

Name ______________________________ Telephone Number ____________________

Street Address ____________________ City ______________ State ______

Zip + 4 ______________

Signature ____________________ Date ____________ Tax ID or SS # ____________

***OFFICIAL USE ONLY***

Group No. ____________ Dept. No. ________ Effective Date ____________

Approved ____________ Date ________ Rejected ____________ Date ____________

## Attachment A

*To be completed only by individuals potentially qualifying for the Health Coverage Tax Credit (HCTC) under the Trade Adjustment Assistance Reform Act of 2002*

**Please attach a copy of the HCTC Program Kit you received.**

Name: ______________________________ Date: ____________________

**Eligibility Certification:**

I certify that I am eligible for Comprehensive Health Insurance Pool (CHIP) coverage as follows:

1. ☐ I am a Nebraska resident;
2. ☐ I am potentially eligible for the Health Coverage Tax Credit available under the Trade Adjustment Reform Act of 2002; and
3. ☐ I am not:
   a. enrolled in a health plan maintained by an employer or former employer that pays (or I pay with pre-tax dollars) at least 50% of the cost of coverage;
   b. entitled to health care under Medicare Part A or enrolled in Medicare Part B;
   c. eligible for a state's Medicaid program;
   d. enrolled in a state's Children's Health Insurance Program (SCHIP);
   e. enrolled in a plan in the Federal Employee's Health Benefit Program (FEHBP);
   f. entitled to health coverage through the U.S. military health system;
   g. eligible to be claimed as a dependent on someone else's federal tax return; or
   h. imprisoned by a federal, state or local authority.

**Premium payments are required on a monthly basis due on the first of each month. It is the applicant's responsibility to ensure timely payment of premium regardless of the status of the receipt of the Advance Tax Credit. Failure to pay premiums in a timely manner could result in termination of your coverage pursuant to the terms of your contract.**

Applicant Signature: ______________________________ Date: ____________________