

- A. Are you covered by or eligible for Medicare, Medicaid or Title XXI (NH Healthy Kids)? Yes No
- B. Do you have other health insurance coverage that you do not intend to terminate? Yes No
If Yes, state name of company _____
- C. Are you eligible for health coverage through your employer or the employer of your spouse, partner by civil union or parent?
 Yes No

Please Note: If the answer is "Yes" to any of the above questions A-C, you are not eligible. No benefits are payable under this policy for any period under which a policy with a prior effective date remains in force.

Other Coverage Information

During the past two years, have you been covered under another health plan (Major Medical, Major Hospital or HMO) with another company? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details below:					
Name	Company Name	Policy/Certificate #	Issue Date	Paid-To Date	Type of Coverage:
					<input type="checkbox"/> Major Med <input type="checkbox"/> Major Hosp <input type="checkbox"/> HMO List Deductible, Maximum Amount, Benefits, etc.

I have a preexisting condition. A preexisting condition is a condition for which symptoms existed within three months prior to the Policy Date that would cause a person to seek diagnosis, care or treatment; or for which medical advice, treatment or service was recommended by or received from a physician within three months prior to the Policy Date; or for a pregnancy existing on the Policy Date. **Please Note:** The policy applied for will not pay benefits for the treatment of certain preexisting conditions. Refer to the Preexisting Condition Limitation provision of the policy. In determining whether a preexisting condition limitation applies, we will credit the time you were previously covered under Creditable Coverage if the Creditable Coverage was continuous (with no break in coverage over 62 days) to a date not more than 63 days prior to receipt of the application. **To get credit toward satisfaction of the preexisting condition period, you must submit certificate(s) or other evidence of all prior Creditable Coverage; telephone verification by prior carrier is also permitted.**

I have received the appropriate Outline of Coverage.

I represent that my answers and statements on this application are true and complete to the best of my knowledge. I understand that if they are not, my policy may not be valid and I may be subject to prosecution for insurance fraud. I understand that all hospitalizations and certain other procedures as specified in my policy must be precertified or benefits will be reduced. I authorize providers of health care to furnish the Administrator with medical information to the extent necessary for processing this application or claims.

Applicant's Signature _____ Date _____

Premium payments will be required on a monthly basis due on the first of each month.

- A check made payable to NHHP for the first monthly premium is submitted with this application.
 A New Hampshire Health Plan Residency Affidavit is submitted with this application.

If you consulted an Agent or Broker regarding this coverage, please have the Agent or Broker complete this section.

AGENT/BROKER USE ONLY (Please Print) Under penalties of perjury, I declare that I am aware of no information contrary to the answers and statements on this application and the New Hampshire Health Plan Residency Affidavit submitted herewith.

Printed Name _____ Telephone Number _____

(Optional) Pay My Commission To _____

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 _____

IMPORTANT NOTICE: Any person who supplies false information in this application or in any application, claim or other matter with respect to the New Hampshire Health Plan (or who assists or encourages any other person to do so), may be subject to prosecution for insurance fraud. Penalties may include fines, license suspension or revocation, and imprisonment.



Non-Tobacco User Affidavit

Under penalty of perjury, I declare that I neither (i) presently smoke or use tobacco products, nor (ii) have smoked or used tobacco products at any time during the 12 months immediately preceding the date of this affidavit. I understand that if I falsely claim the non-tobacco user discount on my application for insurance, I am subject to prosecution under applicable laws (the penalties for a false claim may include criminal charges and/or fines), an obligation to pay the additional premium required of tobacco users and the denial of any claim under the insurance policy for which I am applying.

“Smoke or use tobacco products” for purposes of this affidavit means any use of cigarettes, pipes, cigars or any other tobacco products regardless of the number of times, frequency or method of use.

I, the applicant, have read the above and understand the penalties that may apply if my statements are false.

Date: _____ Printed Name: _____ Signature: _____

For applicants under the age of 18: I am the custodial parent / legal guardian of the applicant. Under penalties of perjury, I declare that the above statements of or on behalf of the applicant are true.

Date: _____ Printed Name: _____ Signature: _____



Residency Affidavit

1. Under penalty of perjury, I declare that I am a resident of the State of New Hampshire as defined in paragraph (3) below. I understand that if I falsely claim to be a resident of the State of New Hampshire, I am subject to prosecution under applicable laws (the penalties for a false claim may include criminal charges and/or fines) and the denial of any claim under the insurance policy for which I am applying.
2. I also understand that this statement will be relied upon in connection with future renewals of the insurance policy for which I am applying and the payment of claims, and that it is my responsibility to inform the New Hampshire Health Plan when I cease to be a New Hampshire resident and that I will be subject to the penalties listed above if I fail to do so.
3. A resident is a person who maintains his or her true, fixed and permanent residence within the State of New Hampshire, does not claim a residence in any other state for any purpose and who has, through all of his or her actions, demonstrated a current intent to designate that the permanent residence is his or her principal place of physical presence for the indefinite future to the exclusion of all others.
4. The permanent residence referred to above is located at

_____ *street address (not P.O. Box)*

_____, New Hampshire _____ *zip*

_____ *city or town*

5. I understand that I may be asked to file an updated affidavit with New Hampshire Health Plan from time to time and other confirmatory proof of residence (e.g., rent receipts, mortgage payments, and utility bills). As often as reasonably possible, I will cooperate when asked to do so.

I, the applicant, have read the above and understand the penalties that may apply if I falsely claim to be a New Hampshire resident.

Date: _____ Printed name: _____ Signature: _____

For applicants under the age of 18: I am the custodial parent / legal guardian of the applicant. Under penalties of perjury, I declare that the above statements of or on behalf of the applicant are true.

Date: _____ Printed name: _____ Signature: _____

My residence is: _____ *street address (not P.O. Box)*

_____ *city or town*, _____ *state* _____ *zip*

My telephone: home: _____ *area code & number* work: _____ *area code & number*