



Administered by:
Benefit Management, Inc. (BMI)
P.O. Box 1090
Great Bend, KS 67530
1-800-877-5187
www.wship.org

Basic Plan (Medicare) Enrollment Packet

Welcome to WSHIP

Enclosed are your Application and enrollment materials from the Washington State Health Insurance Pool (WSHIP). We look forward to assisting you with enrollment in our Basic plan. You are encouraged to use a licensed insurance agent when completing your WSHIP Application; an Agent Directory has been included with this packet for your reference. ***Please review all materials carefully and return your completed Application, along with all required attachments and your 1st month's premium payment, to the address above.***

About WSHIP

The Washington State Health Insurance Pool (WSHIP) is an independent, not-for-profit health plan created by the Washington State Legislature in 1987 to provide access to health insurance coverage for Washington residents and their dependents who are denied individual health insurance. WSHIP coverage is also available to residents of Washington state counties where individual health benefit plans are not offered.

General Eligibility Requirements

- You must be a resident of Washington state;
- You must provide evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a pre-existing conditions limitation on a Medicare supplemental insurance policy; and
- You must be enrolled in both Part A and Part B of Medicare.

Contents of this Enrollment Packet

1. Summary of Benefits for WSHIP Basic Plan (Medicare)
2. Application for Coverage
3. Basic Plan Application Checklist
4. Basic Plan Monthly Premium Rates
5. Low Income Discount Application
6. WSHIP Privacy Notice
7. WSHIP Appeals by Applicants and Participants
8. Agent Directory

How to Contact Us

- **By Phone** (8:00 a.m. – 5:00 p.m. Pacific Time): 1-800-877-5187
- **By Fax:** 1-620-792-7053
- **Via Mail:** WSHIP, P.O. Box 1090, Great Bend, KS 67530
- **On the Web:** www.wship.org

Washington State Health Insurance Pool (WSHIP)

SUMMARY OF BENEFITS

Basic Plan (Medicare)

Administered by: Benefit Management, Inc., (BMI)
PO Box 1090
Great Bend, KS 67530

1-800-877-5187
(8 a.m. to 5 p.m. Pacific Time)
www.wship.org

GENERAL ELIGIBILITY REQUIREMENTS

- You are a resident of Washington state (proof of residency is required);
- You provide evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a pre-existing conditions limitation on a Medicare supplemental insurance policy; and
- You are enrolled in Medicare Parts A and B.

DEPENDENT ELIGIBILITY

Coverage is available for dependent enrolled children under a separate policy with WSHIP. Dependent children are not required to have been rejected for coverage with another carrier. Dependent children must be unmarried, and under the age of 19 (unless disabled).

COST SHARES AND OUT-OF-POCKET EXPENSE LIMITS

The Basic Plan benefits supplement your existing Medicare Parts A and B benefits, as well as providing additional benefits for some services not covered by Medicare. This plan provides no prescription drug coverage except for secondary coverage of drugs covered by Medicare Part B. You pay a fixed percentage of eligible medical expenses (coinsurance) for covered services not covered by Medicare.

Medical Coinsurance	Medical Out-of-Pocket Expense Limit *	Prescription Drug Out-of-Pocket Expense Limit *
None; except 20% for covered services <u>not</u> covered by Medicare Note: WSHIP covers 100% of your Medicare deductible and coinsurance on all medical services covered by Medicare. The 20% coinsurance noted in this Summary applies only to medical services NOT covered by Medicare that are covered by your WSHIP Policy.	\$850	\$150

*Amounts shown are for Individual. Family amount is two times the Individual amount.

Lifetime Benefit Maximum: \$2,000,000 (for all benefits under any WSHIP policy).

Pre-Existing Condition: 6-month wait period unless you were previously covered on a non-catastrophic health plan.

This is only a brief summary of benefits, not a complete plan policy. For more detailed descriptions of benefits, refer to the plan policy. Plan policy supersedes this benefit summary.

SUMMARY OF BENEFITS, Page 2 – Basic Plan

COVERED MEDICAL SERVICES		
BENEFITS	COVERAGE / LIMITATIONS (For services <u>not</u> covered by Medicare Parts A or B)	YOU PAY
	Note: WSHIP covers 100% of your Medicare deductible and coinsurance on all medical services covered by Medicare. The 20% coinsurance noted in this Summary applies only to medical services NOT covered by Medicare that are covered by your WSHIP Policy.	
Acupuncture	12 visits per calendar year	20%
Diabetes Education	Program must be certified; annual deductible waived; \$250 lifetime maximum	10%
Diagnostic Services	Laboratory, pathology, X-rays, imaging and scans	20%
Emergency Room	Covered	20%
Home Health Care	130 visits per calendar year	20%
Hospice and Respite Care	Up to 5 continuous days respite care per 3 months of hospice care	20%
Hospital Inpatient and Outpatient	Covered	20%
Massage Therapy	12 visits per calendar year when prescribed by a physician	20%
Maternity services	Covered	20%
Medical supplies and Equipment	Includes oxygen and prostheses; pre-approval required	20%
Medical Therapies	Chemotherapy, radioisotope, radiation, and nuclear medicine	20%
Mental Conditions and Chemical Dependency	Inpatient 30 days per calendar year; outpatient 28 visits per calendar year	20%
Oral Surgery	Covered	20%
Preventive Care	\$400 annual maximum	20%
Professional Services	Including surgical and anesthesia services	20%
Rehabilitation Therapies	Physical, speech, occupational, and respiratory	20%
Skilled Nursing Facility	100 days per calendar year	20%
Spinal Manipulations	Covered	20%
Transplant Surgery	Pre-approval required; \$250,000 lifetime maximum	20%

COVERED PRESCRIPTION DRUG SERVICES

- This plan provides no prescription drug coverage except for secondary coverage of drugs covered by Medicare Part B.
- Administered by: Medco Health; 1-800- 859-8810; www.medcohealth.com
- Covered prescription drugs must be obtained from WSHIP’s network of pharmacies except when dispensed by an emergency care provider, or a network pharmacy is not available within 30-mile radius of enrollee’s home or prescribing provider’s office, or when prescriptions are filled for antigen and allergy vaccines.

EXCLUSIONS TO COVERED SERVICES

Cosmetic and reconstructive, counseling, custodial care, dental, education and training, fertility, foot care, government facilities, investigational or experimental, military services and war-related, not medically necessary, obesity and weight control, sex or gender reassignment, sexual dysfunction, vision and hearing, work or employment related, and other services or supplies as outlined in the plan policy.

This is only a brief summary of benefits, not a complete plan policy. For more detailed descriptions of benefits, refer to the plan policy. Plan policy supersedes this benefit summary.



APPLICATION for COVERAGE

Washington State Health Insurance Pool

Basic Plan

(Medicare-eligible Plan)

MAIL APPLICATION TO:

BMI (Benefit Management, Inc.)
P.O. Box 1090, Great Bend, KS 67530
1-800-877-5187 or www.wship.org

Please type or print in black ink. All questions must be filled out with complete detail (attach a separate piece of paper if necessary). Incomplete applications may delay the effective date of your policy. If you have questions while completing the application, call WSHIP Customer Service at **1-800-877-5187**.

INFORMATION AND PREMIUM RATES CONTAINED HEREIN ARE SUBJECT TO CHANGE WITH A 30-DAY NOTIFICATION.

SECTION I: AGENT INFORMATION

IF APPLICATION IS BEING MADE THROUGH AN AGENT, THE AGENT MUST PROVIDE THE INFORMATION BELOW. RETURN THIS FORM WITH YOUR APPLICATION.

Agent Name:	Firm or Agency:
Agent Address:	
Agent Phone: ()	Agent email address:
I certify I have verified that all persons applying for coverage are eligible. I further certify, to the best of my knowledge, the information on this application and the Standard Health Questionnaire (if applicable) has been completed truthfully by the Applicant(s).	
Agent Signature	Date
Agent's Washington State License No:	<input type="checkbox"/> Copy of License Attached <input type="checkbox"/> Copy of current license on file with WSHIP
Agent's Tax I.D. Number:	Contact Person: ()
<input type="checkbox"/> Pay commission to agent	OR <input type="checkbox"/> Pay commission to firm
A copy of the agent's current Washington state license and a W-9 form must be submitted with this application, or be on file with WSHIP, for an agent to receive commission payment from WSHIP.	

SECTION II: APPLICANT INFORMATION

Last Name _____ First Name _____ MI _____

Social Security Number _____

Street Address (**required**) _____

City _____ State _____ ZipCode _____

County of Residence _____

Male Female Birth Date ___ / ___ / ___ Age _____

Home Telephone _____ Work Telephone _____

Email address _____

Custodial Parent / Guardian if Applicant is a minor or not legally competent:

Billing Address and Name of Organization / Agency Responsible for Payment, if different from above:

Organization Name _____

Billing Address _____

City _____ State _____ Zip _____

Contact person _____ Phone _____

Receiving DSHS Medical Assistance? _____ Yes No

SECTION III: DEPENDENT INFORMATION

If you are eligible for WSHIP and enroll, you can elect to cover your dependent children. They do not have to be rejected by an insurance carrier. List dependents to be covered. Dependent children must be unmarried, and under age 19 (unless disabled). Additional premiums are required for each dependent AND dependent must be on Medicare Part A and Part B to be eligible for the Basic Plan. A dependent child who does not meet these eligibility requirements may be enrolled in a WSHIP Non-Medicare Plan. Do not use this form for non-Medicare children. Please contact WSHIP Enrollment Department for forms to enroll non-Medicare dependent children.

Dependent A

Last Name _____ First Name _____ MI _____

Social Security Number _____ Birth Date ____/____/____

Disabled and 19 or older? Yes No

If yes, receiving Social Security disability? Yes No Entitlement date ____/____/____

Receiving DSHS medical assistance? Yes No Relationship to Applicant _____

Dependent B

Last Name _____ First Name _____ MI _____

Social Security Number _____ Birth Date ____/____/____

Disabled and 19 or older? Yes No

If yes, receiving Social Security disability? Yes No Entitlement date ____/____/____

Receiving DSHS medical assistance? Yes No Relationship to Applicant _____

Add an additional sheet if you have more dependents.

Is Applicant or any Dependent listed currently insured through WSHIP? Yes No

If **YES**, name of person(s): _____

Relationship: _____

Policy Number: _____

SECTION IV: ELIGIBILITY INFORMATION

I CERTIFY that I am eligible for coverage because I meet the following requirements:

(1) I am a resident of the state of Washington – “resident” means a person who is domiciled in Washington state for purposes other than obtaining insurance. Domicile denotes a person’s permanent home and place of habitation. **You must attach evidence of residency with this application. The evidence must match the home address listed in Section II, page P-2.** Evidence of residency includes, but is not limited to, a copy of:

- a) A bill in your name from any public utility at your dwelling in the state of Washington; or
- b) Receipts for rent, mortgage or lease payments for your dwelling in Washington state; or
- c) A Washington state drivers license or state identification card; or
- d) Proof of registration and payment in Washington of taxes and fees on motor vehicles; or
- e) Proof of employment in Washington state; or
- f) A voter registration card; or
- g) A federal tax return as a resident of Washington state.

(2) I verify that I am enrolled in both Part A and Part B of the federal Medicare program. Please include a copy of your Medicare card with this application. If the dependents listed in this application are enrolled in Medicare Parts A and B, please provide a copy of the Medicare card for each dependent. Dependents must be enrolled in Medicare Parts A and B to be eligible for the Basic Plan. If they are not eligible for these plans, you may enroll them in a WSHIP Non-Medicare Plan.

(3) I also meet one of the ELIGIBILITY CATEGORIES listed below. Please check the eligibility category you are applying under:

REJECTION FOR OTHER HEALTH COVERAGE FOR MEDICAL REASONS

I have received notification of rejection for coverage from a Washington state licensed insurance carrier based on the results of the Standard Health Questionnaire (SHQ). Rejection of an application for a Medicare supplemental plan because the carrier does not offer that plan to those under age 65 will be considered a rejection for medical reasons. **A copy of the insurance carrier’s rejection notice and SHQ scoring page are attached to my WSHIP application.** WSHIP will accept a denial notice for up to 180 days from the date you received the denial letter. Applicants may be required to reapply to a health carrier if the denial was received more than 180 days from the WSHIP application date.

COUNTY WITHOUT ACCESS TO MEDICARE SUPPLEMENTAL COVERAGE

I reside in one of the state of Washington counties where individual health benefit plans are not marketed to the general public by an insurance carrier.

Name of county: _____

SUBSTANTIALLY REDUCED COVERAGE I am a Medicare eligible person who has received substantially reduced coverage on a Medicare supplemental insurance policy from a Washington state licensed carrier due to (1) a requirement of restrictive riders; (2) an up-rated premium; or (3) a pre-existing conditions limitation on a Medicare supplemental insurance policy. A copy of the insurance carrier’s notice is attached to my WSHIP application.

Please Note:

Involuntary termination of other coverage and / or currently disabled with no coverage other than Medicare, by themselves, do not necessarily make you eligible for WSHIP.

NO PERSON IS ELIGIBLE FOR WSHIP COVERAGE IF ONE OF THE FOLLOWING APPLIES TO THEM:

- a) They have terminated coverage in WSHIP within the last 12 months, unless they can show that they had continuous other coverage from the date WSHIP coverage terminated, which has been involuntarily terminated for any reason other than non-payment of premiums;
- b) WSHIP has paid out two million dollars in benefits on their behalf;
- c) They are an inmate of a public institution;
- d) Their benefits are duplicated under public programs; or
- e) They do not reside in Washington state (except qualified resident dependent children temporarily living outside of Washington state).

SECTION V: OTHER COVERAGE

WSHIP will pay secondary to any other coverage unless pre-empted by federal law.

Do you or any person named on this application have any other medical or hospital insurance including public programs such as Medicaid? **Yes** **No**

If **YES**, complete the following for each person(s) (use an additional page if needed):

Last Name	First Name	MI
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Insurance Company Name	Insurance Company Phone No.
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Policy Number	Description of Coverage
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Is it a Group Plan? **Yes** **No** Is it your intent to replace it with this coverage? **Yes** **No**

SECTION VI: PRE-EXISTING CONDITIONS PROVISION

WSHIP plans have a six-month waiting period for pre-existing conditions following the policy effective date. In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. (See below.) To help us determine if you qualify for shortening the pre-existing condition waiting period, please complete the following information and **attach your Certificate of Coverage from your current or prior carrier**. If you do not have a Certificate of Coverage, you may provide other documentation of prior coverage beginning and ending dates (such as a letter from the employer, group administrator or prior insurance carrier) to demonstrate prior coverage beginning and ending dates.

Name of carrier (insurance company): _____

Telephone Number of carrier: _____

Name of subscriber (contract holder): _____

ID Number of subscriber: _____

Names of all enrollees on prior coverage: _____

Date coverage began: _____ **Date coverage ended:** _____

Deductible amount: \$ _____

Out-of-pocket maximum amount per family, per year: \$ _____

Type of coverage: Individual Group Group COBRA

Healthy Options Other Medicaid Medicare Basic Health Plan

Type of benefits (check all that apply): Medical Hospital Only Accident Only

Do you intend to continue this other coverage if you are accepted by WSHIP?

YES **NO** (If no, remember to contact your insurance company to cancel.)

Reduction or Waiver of Pre-Existing Waiting Period

The pre-existing condition waiting period will be waived or credited to the extent you have been covered under a previous medical plan in the following circumstances:

(a) Applicants will receive a pre-existing condition wait credit for time spent in their immediate previous group or non-catastrophic individual plan, if application is made to WSHIP or a health plan carrier within 63 days of termination of that previous plan. (A catastrophic plan means a plan that has \$1,750 or more deductible or \$3,500 or more out-of-pocket cost or provides benefits for hospital inpatient/outpatient services and excludes or substantially limits outpatient physician services and those services usually provided in an office setting).

(b) WSHIP will waive the pre-existing condition wait for any person living in a county without individual coverage who is eligible for such waiver under the standards of the Federal Health Insurance Portability and Accountability (18 months "creditable coverage" and application to WSHIP or a member health plan carrier was made within 63 days of termination).

SECTION VII: DISCLOSURE CERTIFICATION

THIS FORM MUST BE SIGNED BY ALL ADULT APPLICANTS.

By signing this form, I, as an adult Applicant, certify the following:

- a) All of the answers provided for all persons listed as Applicants are true and complete.
- b) I understand that anyone who submits false information may lose coverage, may be held financially responsible for services obtained under WSHIP coverage, coverage may be terminated or rescinded as of the effective date, and I may face other penalties for prosecution and collection. WSHIP may also refund premiums previously paid and

recover claims and administrative costs from you or other persons responsible for the intentionally false information.

- c) WSHIP coverage will not be effective until this application has been signed, submitted in full by the Applicants and approved by WSHIP, and the first month's premium has been paid. Deposit of premium payment does not guarantee coverage. The payment will be refunded for Applicants who are not eligible for WSHIP coverage.
- d) I have read the Privacy Notice at the end of this brochure.
- e) If I have designated someone as my personal representative, I have included the signed Personal Representative Form with this application.
- f) I understand that any changes to Medicare eligibility must be reported to WSHIP within 30 days.

SIGNATURE OF APPLICANT (OR CUSTODIAL PARENT IF APPLICANT IS UNDER AGE 18 OR NOT LEGALLY COMPETENT):	
_____	_____
Signature	Date

Print Name	

SECTION VIII: PREMIUM PAYMENT

PLEASE CHOOSE ONE OF THE PREMIUM PAYMENT OPTIONS BELOW:

- MONTHLY BANK DRAFT** – 1 month premium due with application.
(Complete attached Authorization Form and include a VOIDED check.)
- QUARTERLY** – 3 months premium due with application.
- SEMI-ANNUAL** – 6 months premium due with application.
- ANNUAL** – 12 months premium due with application.

Please note: The billing frequency will be adjusted to the calendar year – quarters, biannual and annual.

MAKE CHECK PAYABLE TO WSHIP

- Use the Basic Plan RATE TABLES enclosed with your Enrollment Packet to determine your premium payment.
- **IMPORTANT: If you are applying for the low income discount, you must first submit the undiscounted premium with your application. If you are approved for the low income discount, your account will be credited.**

NOTE: Any changes to your method of payment or automatic withdrawal, including bank information or termination of monthly bank draft, must be submitted in writing by the 20th of the month prior to the date of that change to have the change implemented the first of the next month.

SECTION IX: EFFECTIVE DATE OF COVERAGE

Please note:

1. The “**Application Received by WSHIP” date** is determined as the date WSHIP receives a faxed copy of your application, or the postmark date of the application that you mailed to WSHIP, whichever occurs first.
2. The original application must be postmarked and mailed to WSHIP no later than five (5) days following the date you faxed the application to WSHIP.
3. Once the application is approved, your insurance coverage and premiums will begin on the first (1st) of the month based on your choice.

Select your effective date of coverage; checkmark only one choice:

AS SOON AS WSHIP CAN PROCESS MY APPLICATION.

I understand that if my application is faxed or postmarked on or before the 20th of the month, then WSHIP coverage will be effective the 1st of the next month. However, if my application is faxed or postmarked after the 20th of the month, my coverage will not start until the 1st of the SECOND month. (Example: Application received by WSHIP July 21, will be effective September 1.)

A FUTURE DATE: This must be on the 1st of the month and can be no more than 60 days later than when your application was faxed or postmarked. (For example, with a postmark date of May 2, your coverage can be effective no later than July 1.)

Tell WSHIP what your Future Date of Coverage should be:

(month) _____ (year) _____

- AN EARLIER DATE:** To select an earlier (*retroactive*) effective date, these two things must be true:
- a) You applied for individual coverage with a Washington state health insurance carrier no later than the 20th of the month for an effective date of the 1st of the following month, and you were rejected; and,
 - b) You are mailing or faxing this WSHIP application within 15 days of receiving that carriers' Notice of Rejection.

If both of the above are TRUE, you may select an effective date that your coverage with the individual carrier would have been effective:

Enter the date of the application to the other carrier _____

Enter Requested Effective Date here: (month) _____ (year) _____

SECTION X: LOW INCOME DISCOUNT

APPLICANTS MAY QUALIFY TO RECEIVE A LOW INCOME DISCOUNT IF THE FOLLOWING APPLIES:

- a) Gross family income is less than 301% of the Federal Poverty Level Guidelines (see income tables at <http://aspe.hhs.gov/poverty/index.shtml> "2007 HHS Poverty Guidelines"; or call WSHIP, 1-800-877-5187 for more information.
- b) Washington state has funds available to support discounts.
- c) Discount does not result in a premium that is less than 110% of the Standard Risk Rate in Washington state for the same benefits.

If you think that you qualify for a discount, you may fill out a **WSHIP Low Income Discount Application**, which is included with this Enrollment Packet.

PREMIUM PAYMENT: If you are applying for the low income discount, you first must pay the amount of basic rates due for one month's premium without a discount in order to activate your coverage.

DISCOUNT LEVELS:

1. If gross family income of an Applicant is more than 250% but less than 301% of the Federal Poverty Level Guidelines, the discount is 15%.
2. If gross family income of an Applicant is less than 251% of the Federal Poverty Level Guidelines, the discount is 30%.

Do not fill out the application for Low Income Discount unless you believe you qualify for the discount. If your income status changes, you must notify WSHIP.

MAIL COMPLETED APPLICATION TO:

WSHIP
ATTN: Enrollment
P.O. Box 1090
Great Bend, KS 67530

**ALL PAGES (P1-P9) OF THE APPLICATION
MUST BE RETURNED**

**IF APPLICATION IS BEING MADE THROUGH AN AGENT, RETURN THE
SIGNED AGENT INFORMATION FORM (SECTION I).**

**All necessary information must be included and appropriate documentation
attached when requested in order for the application to be processed. An
incomplete application will delay the approval process.**

WASHINGTON STATE HEALTH INSURANCE POOL

**BANK SERVICE PLAN
AUTHORIZATION FORM**

TO: The financial institution named on the reverse side.

So that you may comply with your depositor's request, the Washington State Health Insurance Pool (WSHIP) agrees:

- a) To indemnify you and hold you harmless for any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, order or direction to debit an account purporting to be executed by WSHIP and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
- b) In the event that any such check, draft, order or direction shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in forfeiture of that insurance.
- c) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your action taken pursuant to the foregoing request or in any manner arising by reason of your participating in the foregoing plan of premium collection.



Washington State Health Insurance Pool • PO Box 1090 • Great Bend, KS 67530



REQUEST FOR BANK SERVICE PLAN – AUTHORIZATION FORM

TO: Washington State Health Insurance Pool

Please use your Bank Service Plan to make my premium payments by withdrawing funds by automatic debit entry from the account of:

Name as shown on Account Insured / Applicant

Insured / Applicant Identification Number (if you are a NEW Applicant, leave blank)

Name of Financial Institution Branch

City State ZIP

Transit/ABA No. _____ Account No. _____

Please indicate below the type of account to be debited.

Checking

Savings

As a convenience to me, I authorize WSHIP to pay and charge to my account automatic debit entries made upon my account by, and payable to, the order of Washington State Health Insurance Pool. I agree that WSHIP’s rights with respect to each such charge will be the same as if it were personally executed by me. **This authorization is to remain in effect until you receive 15 days’ written notice from me to revoke it.**

X _____ **X** _____
Authorized signature as shown on account Date

WSHIP will withdraw from your account the first Friday of each month except when it falls on the 1st, 2nd, or 3rd. In that case, we will withdraw on the second Friday of the month. If you have any questions, call WSHIP’s Customer Service Dept. at 1.800.877.5186.

ATTACH A VOIDED CHECK HERE:

Please return the Bank Service Plan to:
WASHINGTON STATE HEALTH INSURANCE POOL
P.O. BOX 1090, GREAT BEND, KS 67530

WSHIP BASIC PLAN APPLICATION CHECKLIST

Contact WSHIP Customer Service Dept., 1.800.877.5187; or via email at www.wship.org if you have questions filling out your application form.

- Signature:** Is your application completely filled out and signed in black ink?
- Applicant Information:** If you have a post office box, is a street address also included?
- Dependent Information:** Have you included premium payment for your dependents? Dependent must be on Medicare Part A and Part B to be eligible for WSHIP's Basic Plan.
- Eligibility Information:** Have you selected your eligibility category and included a copy of the documentation for the category you checked?
- Proof of Residency:** Have you included proof of Washington state residency?
- Medicare Card:** Have you included a copy of your Medicare card?
- Rejection notice and a copy of Standard Health Questionnaire scoring page, or substantially reduced coverage notice:** Have you included a copy of the rejection notice and the scoring page of the Standard Health Questionnaire returned to you by the insurance carrier, or substantially reduced coverage notice, which must be on insurance carrier letterhead, signed by an underwriter, addressed to the applicant and be due to the applicant's health?
- Other Coverage:** If this pertains to you, have you included the information about your other medical or hospital insurance, including Medicare or Medicaid?
- Pre-Existing Conditions:** If the Pre-existing Waiver Benefit applies to you and your coverage was an individual plan, did you include a Certificate of Creditable Coverage from your previous insurance carrier, or other documentation to demonstrate beginning and ending dates of that coverage?
- Disclosure Certification:** Have you signed the Disclosure Certification?
- Premium Payment:** Did you identify a premium payment cycle (Monthly Bank Draft, Quarterly, Semi-Annual, or Annual), and have you checked the Premium Rate Table you used? Have you included the premium payment due according to the payment cycle chosen?
- Effective Date of Coverage:** Have you selected the date you wish your coverage to begin?
- Low Income Discounts: NOTE: If you are applying for the Low Income Discount, you first must pay the amount of basic rates due for one month's premium without a discount in order to activate your coverage.** If you are approved for the low income discount, your account will be credited. To apply for the Low Income Discount, submit the enclosed Low Income Application Form with your WSHIP Application.
- Bank Service Plan Authorization Form:** If you chose the Monthly Bank Draft premium payment cycle, did you include one month's premium? Did you complete, sign and enclose the "Request for Bank Service Plan – Authorization Form"? Did you attach a voided check?
- Personal Representative:** If you wish to designate a Personal Representative, have you filled out and signed the form?

All necessary information must be included and appropriate documentation attached in order for application to be processed.

An incomplete application will delay the approval process.