TEXAS Health Insurance Pool

Send Completed Application to Policy Administrator
Blue Cross and Blue Shield of Texas[+]
P. O. Box 6089
Abilene, TX 79608-6089
Toll Free Number: 1-888-398-3927

SECTION A: APPLICANT INFORMATION (please print)

An incomplete application will be delayed and the effective date of your coverage may change if all required information is not received. Use black ink only.

First Name	M.I.	Last Name	☐ Jr. ☐ III ☐ Sr. ☐ IV ☐ II	☐ Mr. ☐ Ms. ☐ Miss ☐ Dr. ☐ Mrs.

Social Security #	Date of Birth / Country of Birth	Sex	Marital Status	Do you use tobacco?*
		☐ Male ☐ Female	☐ Single ☐ Divorced ☐ Married ☐ Widowed For Divorced or Widowed: _____ (Date)	☐ Yes ☐ No

Home Street Address / Apt. No.	Mailing Address (if different from Home Street Address)

City	State	Zip Code	City	State	Zip Code

Email Address	Home/Cell Telephone #s	Work Telephone #

Name of Custodial Parent (if applicant is a minor)	Custodial Parent's Social Security #

Name of Emergency Contact	Home/Cell Telephone #s	Relationship

SECTION B: DEPENDENTS TO BE COVERED

List qualified dependents to be covered (see definition of dependents in Outline of Coverage). A separate policy will be issued to each eligible dependent.

First Name	M.I.	Last Name	Relationship to Applicant	Social Security #	Date of Birth	Country of Birth	Sex	Use tobacco?*
							☐ M ☐ F	☐ Yes ☐ No
							☐ M ☐ F	☐ Yes ☐ No
							☐ M ☐ F	☐ Yes ☐ No
							☐ M ☐ F	☐ Yes ☐ No
							☐ M ☐ F	☐ Yes ☐ No

* Smoked cigarettes, cigars or a pipe or used chewing tobacco, nicotine chewing gum or snuff in the 12 months prior to this application.

[+] A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of Blue Cross and Blue Shield Association

SECTION C: ELIGIBILITY

1. Eligibility Information (mark all situations that apply):

☐ I am a US Citizen or a permanent legal resident of the U.S. for at least 3 continuous years. Proof may be required.

☐ I am a resident of the State of Texas. **Attach a readable copy of one of the following:**

- **front and back of your valid driver's license**
- **current voter registration card**
- **current utility bill indicating your physical address**

If applicant is a child under age 18, provide proof of residency for parents. If a dependent age 18 or older or a spouse is included, attach proof for each person.

☐ I had health insurance coverage for at least 18 months preceding this application with no gap of coverage greater than 63 days and the most recent coverage was through an employer health plan provided by a U.S. private employer, church or governmental entity or another state's high risk pool. I have also exhausted all COBRA or state continuation coverage offered to me. **Send a copy of the Certificate of Creditable Coverage or documentation of the prior coverage. IF THIS BOX IS CHECKED, DO NOT COMPLETE SECTION 2 BELOW.**

2. Evidence of One of the Following Must Be Provided (mark one section and provide required documentation):

☐ I have received a notice of rejection or refusal to issue substantially similar individual health insurance for health reasons by an insurer. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant shall not be sufficient evidence. **Send a copy of the rejection letter from the insurance carrier.**

☐ My agent has certified that he/she is unable to obtain substantially similar individual health insurance for me with the insurance carrier he/she represents because I will be declined for coverage, as a result of my medical condition, based on the insurance carrier's underwriting guidelines. **Agent must complete Section I: AGENT INFORMATION.**

☐ I have been offered substantially similar individual health insurance coverage, but with a conditional rider excluding coverage for a medical condition. **Send a copy of the letter from the insurance carrier that includes the conditional rider exclusion. Note: COBRA and association group coverage are not considered individual coverage.**

☐ I have been diagnosed with or treated for one of the following medical or health conditions within the past 5 years. **Send a signed and dated letter from your physician's office, stating the specific diagnosis and date of diagnosis and date of last treatment. Please DO NOT send medical records. Check the condition(s) in the following list that applies to you:**

- ☐ Addison's Disease
- ☐ AIDs/HIV
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Angina Pectoris
- ☐ Arthrogryposis
- ☐ Artificial Heart Valve
- ☐ Brain Tumor
- ☐ Bronchopulmonary Dysplasia
- ☐ Cardiomyopathy
- ☐ Cerebral Palsy
- ☐ Childhood Asthma
- ☐ Chronic Liver Failure
- ☐ Cirrhosis (non-alcoholic)
- ☐ Congenital Heart Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Cystic Fibrosis
- ☐ Dementia (including Alzheimer's)
- ☐ Dermatomyositis
- ☐ Diabetes Mellitus
- ☐ Down's Syndrome
- ☐ Epilepsy
- ☐ Fredrich's Ataxia
- ☐ Guillian-Barre Syndrome
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hodgkin's Disease
- ☐ Huntington's Chorea
- ☐ Hydrocephalus
- ☐ Inborn Errors of Metabolism
- ☐ Intermittent Claudication
- ☐ Lead Poisoning with Cerebral Involvement
- ☐ Leukemia
- ☐ Leukodystrophies
- ☐ Lupus
- ☐ Metastatic Cancer
- ☐ Muscular Atrophy or Dystrophy
- ☐ Myasthenia Gravis
- ☐ Myotonia
- ☐ Organ Transplants (except Corneal)
- ☐ Paraplegia or Quadriplegia
- ☐ Parkinson's Disease
- ☐ Pediatric Craniofacial Abnormalities
- ☐ Peripheral Vascular Disease
- ☐ Polyarteritis Nodosa
- ☐ Polycystic Kidney
- ☐ Polymyositis
- ☐ Psychotic Disorders
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Sclerosis, Multiple, Disseminated or Posterolateral
- ☐ Short Bowel Syndrome
- ☐ Sickle Cell Anemia
- ☐ Silicosis (Black Lung)
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Syringomyelia
- ☐ Tabes Dorsalis (Locomotor Ataxia)
- ☐ Tumor, Malignant
- ☐ Ulcerative Colitis
- ☐ Wilson's Disease

SECTION C: ELIGIBILITY - cont. (check all situations that apply)

Check all that apply with respect to you or any other person listed on this application (if one of these applies, you may not be eligible for coverage with the Texas Health Insurance Pool):

Eligible for:

- ☐ Medicare (send a copy of your Medicare card)
- ☐ Medicaid (send a copy of your Medicaid card)
- ☐ Employer Group
- ☐ Association Group Policy
- ☐ COBRA
- ☐ State continuation
- ☐ Conversion Policy
- ☐ Other Health Insurance

Check all that apply to you or any other person listed on the application:

- ☐ Currently confined to a county jail or a state prison
- ☐ Previously received benefits from the Texas Health Insurance Pool (any benefits received will reduce benefits available under a subsequent policy; $3,000,000 lifetime maximum).
- ☐ Had prior coverage with Texas Health Insurance Pool that was terminated for fraud.
- ☐ Terminated or lapsed coverage with the Texas Health Insurance Pool within the last 12 months.

SECTION D: EMPLOYMENT INFORMATION

Are you	☐ employed	☐ self-employed or	☐ unemployed/retired
	If unemployed or retired, date last employment ended: _____ If unemployed or retired less than 18 months, provide last employer name_____ and telephone number_____		
Is your spouse	☐ employed	☐ self-employed or	☐ unemployed/retired
	If unemployed or retired, date last employment ended: _____ If unemployed or retired less than 18 months, provide last employer name_____ and telephone number_____		

If application is made for a person under age 26, employment information must also be provided for each parent and step-parent (if applicable) and the child (if applicable).

If you are employed, your employer and, if you are married, your spouse's employer, must complete and sign the **Employment Verification Form**. Your spouse's information must be provided, even if your spouse is not applying for Pool coverage.

If you or your spouse is self-employed, you or your spouse must complete the **Self-Employment Verification Form** for your business. Your spouse's information must be provided, even if your spouse is not applying for Pool coverage.

SECTION E: OTHER INSURANCE

Supply the following information for the past 18 months for each person to be insured. **If a dependent had different coverage, provide information regarding coverage of each dependent. Attach a separate piece of paper if necessary. Please provide the Certificate of Creditable Coverage or other documentation for all health coverages in the past 12 months for credit against the preexisting condition exclusion period. If you are currently on Medicare, please send a copy of your Medicare card.**

Name of Insured		Date coverage terminated *
Name of previous health coverage carrier or health plan		Telephone number of previous carrier or plan
Name of employer providing coverage (if any)		Telephone number of employer
Identification number of coverage		Group number (if any)
How long were you covered?	From / /	To / /
Is coverage still in force? ☐ YES ☐ NO	If **NO**, Why did coverage terminate?	

* If coverage is still in force - report "current" or scheduled termination date, if any.

SECTION F: HEALTH HISTORY

Have you or any person to be covered by the Texas Health Insurance Pool received or had recommended medical advice, care or treatment, including taking prescription drugs, within the past six months? ☐ YES ☐ NO If **YES**, provide the following information. If more than one condition has been treated or family members are to be covered and additional space is needed, attach a separate piece of paper providing the requested information for each condition of each person to be covered.

Name of Person Treated	Date of Advice/Care/Treatment
Advice, Care or Treatment Received	
Condition Treated	Treating Physician

Name of Person Treated	Date of Advice/Care/Treatment
Advice, Care or Treatment Received	
Condition Treated	Treating Physician

Name of Person Treated	Date of Advice/Care/Treatment
Advice, Care or Treatment Received	
Condition Treated	Treating Physician

Name of Person Treated	Date of Advice/Care/Treatment
Advice, Care or Treatment Received	
Condition Treated	Treating Physician

SECTION G: APPLICANT'S DISCLOSURE AUTHORIZATION AND DECLARATION

I declare that no person named in this application is currently covered by a Texas Health Insurance Pool policy. The foregoing statements and answers are full, complete, and true to the best of my knowledge and belief; and any coverage issued will be in full reliance upon this representation. I understand and agree that no coverage shall be effective until all requirements have been completed. I understand and agree to pay an application fee equal to the premium mode I have selected. This payment is only a deposit that will be returned if my application is denied or applied to any premium charges if my application is accepted. I understand and agree that the deposit of my application fee does not constitute acceptance of my application by the Texas Health Insurance Pool.

I understand and agree that referring agents are not authorized to interpret, amend, or alter the terms of the Texas Health Insurance Pool policy, nor are referring agents authorized to bind Texas Health Insurance Pool in any way. I understand and agree that premiums charged for coverage and the coverage provided by the Texas Health Insurance Pool are subject to change by the Board of Directors. **I understand that my coverage will not become effective until approval and acceptance of the application by Texas Health Insurance Pool.**

I understand that my or my dependent's preexisting conditions, including any condition indicated on page 2 or page 4 of this application, will not be covered by the Texas Health Insurance Pool policy during the preexisting condition exclusion period. I further understand that if I provide proof of my or my dependent's prior creditable coverage, I or my dependent may be approved for a waiver or partial waiver of the preexisting condition exclusion period. A preexisting condition is a disease or medical condition: for which the existence of symptoms would cause an ordinarily prudent person to seek diagnosis, care or treatment during the six months before an insured person's effective date of coverage; or for which medical advice, care or treatment was recommended or received during the six months before an insured person's effective date of coverage. Preexisting condition includes a preexisting pregnancy or a complication of a preexisting pregnancy, whether the complication occurs before or after the effective date of coverage. Preexisting condition does not include genetic information, in the absence of a diagnosis of the condition related to the genetic information.

I permit any physician, pharmacist, hospital or other health care provider, insurer, prepayment organization or other health plan provider to give the Texas Health Insurance Pool, the Administrator or its designated representative any medical information about me or my dependents, including information about physical and mental health, medical history and drug or alcohol use. This information will be used to evaluate your eligibility for the Texas Health Insurance Pool policy and claims for benefits. A reproduction of this authorization shall be as valid as the original.

The information I provide on this form and any attachments is private data under Texas law. The law does not require me to provide any data, but failure to do so will result in loss of eligibility for the Texas Health Insurance Pool. By providing this data, I authorize the Texas Health Insurance Pool and its Administrator to use and disclose the data as follows: any data I provide may be made available to the employees, agents, directors, officers of the Texas Health Insurance Pool, the Administrator or legal counsel. It may also be made available to provider peer review panels or consultants, the actuarial or research organizations, or other persons authorized by law to receive such data.

I have read the above statement, and I agree to supply the data on this form with full knowledge of the information provided in that statement. If I am applying based on an agent's certification of my ineligibility for substantially similar coverage from an insurer or health maintenance organization, based on my medical condition(s), I hereby certify that the medical information provided on this application by the agent is correct and I agree that a copy of the agent's statement, SECTION I, may be furnished to the named insurer or HMO.

Signature of Applicant **X**	Date	Signature of Custodial Parent (if applicant is under age 18) **X**	Date
Print Applicant Name		Print Custodial Parent Name (if applicable)	

SECTION H: COVERAGE & PREMIUM PAYMENT SELECTIONS

WHEN WOULD YOU LIKE COVERAGE TO BEGIN?

☐ Specific Date: _____ or ☐ First Available

Please allow at least 8 business days following receipt of your complete application.

YOU MAY SELECT A DIFFERENT PLAN FOR EACH PERSON TO BE COVERED.

Please note, a later change to a lower deductible is not allowed. Only one increase in the deductible will be allowed during a calendar year.

Plans Available for Persons Not Eligible for Medicare

I R	$1,000 Medical Deductible, $200 Rx Deductible	**IV R**	$7,500 Medical Deductible, $500 Rx Deductible
II R	$2,500 Medical Deductible, $200 Rx Deductible	**V R**	HDHP HSA-Qualified, $3,000 Medical Deductible, $1,450 Rx Deductible
III R	$5,000 Medical Deductible, $200 Rx Deductible		

Plans Available for Persons Eligible for Medicare

I M	$1,000 Deductible (No Rx Benefit)	**II M**	$2,500 Deductible (No Rx Benefit)

INITIAL PREMIUM CALCULATION TABLE/PREMIUM PAYMENT OPTIONS

Using this table, calculate the amount of initial premium due with this application and select your future payment method. Initial payment should be by personal check, money order or cashier's check payable to **Texas Health Insurance Pool**, which must be submitted at the time of application, regardless of the future payment method selected.

	Applicant's/Dependent's First Name	Age	Sex	Tobacco user?*	First 3 Digits of Zip Code	Plan Selected (insert I R, II R, III R, IV R, V R, I M or II M)	Applicable premium amount from rate table**
1							
2							
3							
4							
5							
6	**Subtotal of premium rates for each person to be covered (add rows 1- 5)**						$
7	**Select your payment method (must be the same for all persons to be covered)** ☐ Annual (Direct Bill once a year)						Multiplier 12
	☐ Semi-Annual (Direct Bill twice a year)						6
	☐ Quarterly (Direct Bill once every 3 months)						3
	☐ Monthly Automatic Bank Deduction (see below)						1
8	Multiply line 6 by multiplier for your selected payment method. **THIS IS THE AMOUNT THAT MUST BE INCLUDED WITH THIS APPLICATION**						TOTAL PREMIUM INCLUDED $

FOR MONTHLY AUTOMATIC BANK DEDUCTION, a personal check, money order or cashier's check, in the amount of one month's premium, payable to the Texas Health Insurance Pool, must be submitted with the application. You must also attach a voided check (not a deposit slip) with the correct account number and you must complete the authorization agreement on the next page. The automatic bank deduction will begin with the second month's premium payment.

*Smoked cigarettes, cigars or a pipe or used chewing tobacco, nicotine chewing gum or snuff in the 12 months prior to this application.

**Premium amount is calculated based on age on the policy effective date.

Complete this section only if you are requesting to pay premiums monthly.

Authorization Agreement for Monthly Automatic Bank Deduction of Insurance Premium

Complete and sign the Authorization Agreement for monthly Automatic Bank Deduction of Insurance Premium if you have chosen monthly payments. Please note:

- **Attach** a sample of your check marked "VOID".
- Verify your account number with your banking institution. (Frequently, the account number listed on a check includes or removes digits from the actual account number.)

As a convenience to me (or us if this is a joint account), I (we) hereby request and authorize you to pay and charge to my (our) account checks or electronic debits drawn on my (our) account by you and payable to the order of the Texas Health Insurance Pool. I (we) agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me (us). This authority is to remain in effect until revoked by me (us) in writing and until you actually receive such notice. I (we) agree that you shall be fully protected in honoring any such check or electronic debit.

I (we) further agree that if any such check or electronic debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Name of Account Holder(s) 1. 2.			
Bank Name			Checking Account Number: (Do not use a savings account.)
Bank Address			
City	State	Zip Code	Routing Number:

Signature of Account Holder(s)

Name (please print)		Name (please print)	
Signature **X**	Date	Signature **X**	Date

To The Financial Institution named: In consideration of your participating in a plan which the Texas Health Insurance Pool ("Company") has put into effect by which amounts due on policies of insurance are collected by checks drawn or pre-authorized electronic debits originated by the Company on the accounts of persons who are responsible for these payments, the Company does hereby agree that:

(1) It will indemnify and hold you harmless from any liability to any person arising out of the payment by you of any check or electronic debit, whether or not genuine, originated by the Company in the regular course of business for the purpose of payment, or arising out of the dishonor by you whether with or without cause, or intentionally or inadvertently, of any such check or electronic debit, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy of insurance the premium on which is sought to be collected by the Company by any such check or electronic debit; and

(2) Without limitation on the foregoing indemnities, it will refund to you any amount erroneously paid by you on any such check or electronic debit if claim for the amount of such erroneous payment is made by you within six months from the date of the check or electronic debit on which such erroneous payment was made; and

(3) Your participation in the plan or that of the depositor may be terminated by written notice from either party to the other, likewise, your participation and that of the Texas Health Insurance Pool may be terminated by 30 days written notice from either party to the other.

Texas Health Insurance Pool

D. Gregory Barbutti
Secretary/Treasurer
Authorized in a resolution adopted by the Board of Directors

SECTION I: AGENT INFORMATION (if applicable)

THIS FORM MUST BE COMPLETED BY THE AGENT, IF ANY, WHO ASSISTED WITH THIS APPLICATION. ALL FIELDS MUST BE COMPLETED BY THE AGENT TO RECEIVE THE $100 AGENT REFERRAL FEE.

Agent Name (Printed)			Texas Insurance License No.
Business or Agency Name			Agent Social Security or Federal Tax ID #
Business or Agency Address			Work and Fax Telephone Numbers
City	State	Zip Code	Email Address

I understand that Texas Insurance Code statutes, §1501.352 and §1506.159 prohibit an agent from attempting to arrange or assist in excluding an eligible individual from an employer health benefit plan, specifically by attempting to arrange or assist in obtaining coverage from the Texas Health Insurance Pool. I further understand that preparing or causing to be prepared a statement, which an agent knows contains false or misleading material information, and which is presented to an insurer, is insurance fraud, in violation of Sec. 35.02, Texas Penal Code. I hereby certify that, if the applicant is employed, his employer does not have employer health coverage in effect nor does the employer intend to obtain such coverage within the six months after the date of this application. I further certify that, to the best of my knowledge and belief, the employer does not pay or reimburse, directly or indirectly, the premium for employee health insurance, including through the use of a health reimbursement account (HRA), Section 125 (Cafeteria Plan) or similar arrangement.

Agent's Signature **X**	Date

If Agent is certifying an applicant's eligibility under Section C: ELIGIBILITY, Agent must also complete the following

Name of Applicant	Name and address of Insurer or Health Maintenance Organization that will NOT accept Applicant.
Medical Condition and Approximate Date(s) of Diagnosis	Name and Address of Attending Physician

I hereby certify that I believe I am unable to obtain individual health insurance substantially similar to the coverage offered by the Texas Health Insurance Pool for this applicant from any insurer or HMO, with which I am appointed, including the indicated insurer, because the current underwriting guidelines of such insurer or HMO reflect a declination for the applicant's medical condition(s).

Agent's Signature	Date

The Pool reserves the right to require an attending physician's statement. A copy of this certification may be provided by the Pool to the named insurer or HMO.