

Step 2: Coverage Options

1. Have you been rejected or refused comprehensive coverage due to health reasons? Yes No
 2. Has an insurance company offered you coverage that has a rider that does not cover your medical condition? Yes No
 3. Identify your primary health condition: _____
Identify the primary health condition that prevents you from obtaining standard insurance coverage.
 4. If you answered "No" to questions 1 & 2, do you have one of the presumptive medical conditions as outlined in the Summary of Coverage? Yes No
 5. How will the monthly premium be paid? recurring ACH debit or monthly invoice credit card charge
Recurring debit and credit card transactions require completed authorization forms. If paying by credit card, there will be a \$5 convenience fee added to each premium payment.
 6. Who will be paying the premium? applicant/spouse spouse parent other
joint account non-joint account
- If Other, explain: _____

Step 3: Most Recent Health Insurance/Health Plan Information

1. When was the last time you had health insurance coverage?
 < 6 months 6 months to 1 yr > 1 year or never
2. When did or will this health insurance coverage end? _____
2a. Describe the type of health insurance coverage: *MM/DD/YYYY*
Group Health Plan or Group Insurance Coverage Medicare Medicaid Church Plan
Individual Health Insurance Policy Federal or other Government Employees Plan
CHIP or other State Risk Pool Other (describe) _____
- 2b. Why did coverage end? _____
3. _____
insurance company name or health plan name policy # or plan # phone # with area code
4. Are you eligible for Medicare? Yes No
5. Are you receiving any type of Medical Assistance including All Kids from the Illinois Department of Healthcare & Family Services or like agencies? Yes No
5a. If Yes, provide the Medical Assistance ID number(s). _____

Step 4: Required Documentation

1. To prove Illinois residency, attach a copy of your current valid Illinois driver's license, an ID card issued by the Illinois Secretary of State or the most recent resident Illinois Income Tax Return (IL-1040). This documentation must reflect the current residential address. Refer to the Summary of Coverage Brochure for additional information about residency.
2. If you are currently insured, attach a copy of the policy.
3. If you are a U.S. Citizen submit a copy of your birth certificate, passport or your certificate of naturalization. If you are lawfully present in or a national of the U.S. attach either the USCISI-551 or other residency documentation.
4. If you have had coverage within the past 12 months, submit a "Certificate of creditable coverage" that verifies when you were last insured.
5. Attach a copy of one of the following:
 - (a) a rejection letter from a health insurance company or plan for comprehensive coverage stating that you are ineligible due to health reasons; or
 - (b) a physician's statement verifying that you have one of the physical or medical conditions considered by the plan to be a presumptive medical condition or a statement from a physician that you have an existing health condition. (Your physician can complete the attached form instead); or
 - (c) the notice to issue coverage but with a rider that does not cover your medical condition.

Step 5: Important Information

You can send a check or money order/pay your 1st month's premium with the application. If the premium is not included with your application, once the application has been processed we will contact you and let you know how much premium to send. Premium rate tables can be found at insurance.illinois.gov/ipxp or call toll free at 877-210-9167 (TTY/TDD: 866-883-8551).

You will not be able to enroll or have any coverage under this state program until the application and any subsequent information has been approved and payment for the full initial premium has been received and honored.

By your signature below, you agree to the following statements:

- ▶ My responses as recorded in this application are full, complete and true to the best of my knowledge and belief.
- ▶ I am not currently covered under any group health plan, any other health insurance coverage, Medicare, medical assistance provided by the State of Illinois or any other state. Any coverage that ultimately may be issued will terminate as of the date that I obtain or become eligible for other coverage as described above.
- ▶ Any coverage provided by the IPXP will be based on the information disclosed in this application, a copy of which will be attached to and made a part of any benefit plan booklet which may be issued to me.
- ▶ No plan coverage will be effective unless and until payment for the initial premium has been received and honored and all other requirements have been met and approved by IPXP.
- ▶ Any plan coverage issued can be rescinded as of the original issue date if it is later determined that any of the information contained in or supplemental to this application is false or inaccurate.
- ▶ I will immediately lose my eligibility for IPXP if I move outside the State of Illinois.
- ▶ I authorize any insurance issuer, insurance service or organization, group health plan, administrator, provider, institution or person that has my records or knowledge of my health history to give such information to IPXP or its designated representative.

signature of applicant

date

signature of custodial parent if the applicant is a minor or Legal Guardian if legally incompetent.

date

Have You?

- | | | |
|---|------------------------------|-----------------------------|
| Completed a separate application for each person applying for coverage? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Signed and Dated the Application? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Answered all questions completely? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Attached all documents as required? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Carefully read and reviewed all your answers to ensure their accuracy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Step 6: Forward this Application* and all documentation to:

Health Alliance Medical Plans
Attn: Illinois Pre-Existing Condition Health Insurance Plan (IPXP)
301 S. Vine St
Urbana, Illinois 61801

***If you are submitting this application electronically you need only submit by mail the required documentation under Step 4.**

If you have questions you can call toll free at 877-210-9167 (TTY/TDD: 866-883-8551).