



Maryland Health Insurance Plan

**Application For Coverage**

# Application Requirements Check List

## PLEASE READ THE FOLLOWING INSTRUCTIONS

If you do not include ALL of the required documentation, your application will be delayed.  
If two or more items are missing, your application will automatically be denied.

**Proof of Eligibility – Applicant must document eligibility for coverage (except those applying as Trade Adjustment Assistance or PBGC recipients). Please submit one of the following:**

- Letter from insurance company denying you coverage dated within the past 6 months; **OR**
- Acceptance letter for an individual insurance policy with an exclusionary rider for a pre-existing condition dated within the past 6 months; **OR**
- Copy of a premium statement from your current policy or a written quote dated within 60 days from an individual insurance policy that shows a higher rate than Maryland Health Insurance Plan; **OR**
- Physician's statement documenting a medical condition that is on the list included on page 4 of this application; **OR**
- Certificate of creditable coverage and a copy of identification card from another state's high-risk pool.

**AND**

**Proof of Residency – You must document Maryland residency. Please submit one of the following:**

- A copy of your Maryland driver's license (required for those applying as Trade Adjustment Assistance or PBGC recipients); **OR**
- Other proof of Maryland residency.

**AND**

**Premium Check: You must include a check for the first month's premium.**

- Make checks payable to Maryland Health Insurance Plan.
- Personal check only. NO business checks or DBA checks accepted.

Failure to submit completed applications and required documentation will result in a delay in activating your enrollment.

**Mail your completed application with required documentation to:**

**MHIP Enrollment Department  
P.O. BOX 47160  
Baltimore, MD 21244-7160**

## A. Applicant Information

Please complete all sections in black ink. If you make an error, you must initial the change.

Last Name:		First Name:		MI:	Age:	Birthday (MM/DD/YYYY):	
Address:				City:	State:	Zip:	
Mailing and/or Billing Address if Different:						County:	
Social Security Number:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	E-mail Address:		Home Phone:	Work Phone:		

## B. Health Coverage Options

Select one of the following coverage options:  Subscriber only  Subscriber and Children  
 Subscriber and Spouse  Subscriber and Family Coverage

Select the plan you want to enroll in.

All family members must enroll in the same plan (either the PPO or the EPO Network plan):

**PPO Plan**

\$1,000 Deductible

Co-insurance-20% In-network/40% Out-of-Network

**EPO Network Plan**

No Deductible/\$20 PCP co-pay/\$30 Specialist co-pay  
\$250 Inpatient hospital co-pay

**List all dependents you want to enroll. If you have more than 3 dependents, attach additional sheets of paper.** *If you enroll in the EPO plan, you must select a primary care physician (PCP) for each person enrolling. You may select a different PCP for each family member. To select a PCP, refer to the on-line provider directory at [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us)*

Self:				PCP (EPO only):	Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse: (Last, first, middle initial)	Same address as applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthday:	PCP (EPO only):	Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
SSN:					
Dependent Child's Name:	Same address as applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthday:	PCP (EPO only):	Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
SSN:					
Dependent Child's Name:	Same address as applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthday:	PCP (EPO only):	Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
SSN:					

## C. Health Conditions

**Health status will not disqualify you for MHIP coverage or increase your premium. This information will assist us in providing for your health care needs. Please check all health conditions for which you have been treated or diagnosed in the past six months.**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Hypertension    |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Colon Problem          | <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Kidney Problem  |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Liver Condition |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Eye Diseases           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Back Condition     | <input type="checkbox"/> Gynecological Problems | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Obesity         |
| <input type="checkbox"/> Breast Disease     | <input type="checkbox"/> HIV Positive           | <input type="checkbox"/> Hip Disorder        | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Other _____        |   |  |  |

## D. Certification of Eligibility

### Coverage Eligibility

In order to be eligible for coverage through Maryland Health Insurance Plan (MHIP), you must meet one of the following four separate eligibility tests: **medical eligibility, loss of group coverage eligibility, transfer from another risk pool eligibility, or Federal Trade Adjustment Assistance eligibility.** Check the boxes below that apply.

#### 1) Medical Eligibility

**You are eligible for MHIP if BOTH of the following applies:**

- You have been a resident of the State of Maryland for **at least six months** prior to making this application. *(Attach a copy of the front and back of your current Maryland driver's license. As an alternative, you may attach a copy of other documents issued within the last 6 months showing your Maryland address, such as a voter registration card or utility bill in your name).*
- You are not enrolled or eligible for Medicare Part A or Part B, Medicaid, coverage under any employer-sponsored group health benefits program, or Maryland Children's Health Insurance Program.

**AND**

**If ONE of the following applies:**

- Within the last six months, you have been denied health insurance coverage due to health reasons. *(Attach a copy of the letter denying coverage).*
- You currently have, or have been offered, health insurance that provides limited or restricted coverage, or that excludes coverage for a specific medical condition or conditions. *(Attach a copy of an acceptance letter for an individual insurance policy that includes an exclusionary rider for a pre-existing condition).*
- You currently have, or have been offered, individual health insurance coverage, however, the premium rate exceeds the MHIP premium for similar coverage due to a health condition. *(Attach a copy of a premium statement from your current policy or a written quote from a carrier that shows a higher rate than MHIP).*
- You have one of the specific medical conditions listed on page 4 of this application. *(See information on next page that provides details on required proof.)*

**The requested documentation noted above must accompany this application, and must be dated within the last six months.**

## D. Certification of Eligibility (continued)

### 1) Medical Eligibility (continued) - Proof of Medical Eligibility

Please check below the condition for which you have been treated or diagnosed.

<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Myotonia
<input type="checkbox"/> AIDS	<input type="checkbox"/> Type I diabetes	<input type="checkbox"/> Non-Hodgkins lymphoma
<input type="checkbox"/> Angina pectoris	<input type="checkbox"/> Friederich's ataxia	<input type="checkbox"/> Palsy
<input type="checkbox"/> Ascites	<input type="checkbox"/> Guillain Barre syndrome	<input type="checkbox"/> Paraplegia or quadriplegia
<input type="checkbox"/> Metastatic cancer	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Hodgkin's disease	<input type="checkbox"/> Psychotic disorders
<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> Hydrocephalus	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> Chronic obstructive pulmonary disease	<input type="checkbox"/> Kidney disease requiring dialysis	<input type="checkbox"/> Sickle cell disease
<input type="checkbox"/> Cirrhosis of the liver	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Cerebrovascular accident (stroke)
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Lupus erythematosus disseminate	<input type="checkbox"/> Syringomyelia
<input type="checkbox"/> Coronary insufficiency	<input type="checkbox"/> Multiple myeloma	<input type="checkbox"/> Tay-Sachs disease
<input type="checkbox"/> Coronary occlusion	<input type="checkbox"/> Multiple or disseminated sclerosis	<input type="checkbox"/> Ulcerative colitis
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Muscular dystrophy	<input type="checkbox"/> Wilm's tumor
	<input type="checkbox"/> Myasthenia gravis	<input type="checkbox"/> Wilson's disease

### Instructions

**Applicant:** Please have a licensed physician write a letter on the physician's stationery confirming that you have been diagnosed or treated for the condition you checked above.

The letter must include the following elements:

- Physician's full name
- Physician's address
- Physician's specialty
- Physician's license number

**Physician:** Please complete the letter confirming that the applicant has been diagnosed or treated for the condition indicated above. Return the letter to the applicant so it can be included with his or her MHIP application.

## D. Certification of Eligibility (continued)

### 2) Loss of Group Health Coverage Eligibility (HIPAA eligibility)

**You are eligible for MHIP if ALL of the following criteria apply:**

- You are a resident of the State of Maryland. *(Attach a copy of the front and back of your current Maryland driver's license or other recent documents showing your Maryland address, such as a voter registration card or utility bill in your name).*
- You are not enrolled or eligible for Medicare Part A or Part B, coverage under any employer-sponsored group health benefits plan, Medicaid, or Maryland Children's Health Insurance Program.
- If available, you have elected and exhausted health insurance benefits through COBRA or a similar state or federal continuation. (COBRA is employer health coverage for which you pay the full cost in order to extend your coverage as a result of certain qualifying events, such as termination of employment or divorce).
- You have 18 months of creditable coverage with the most recent coverage under an employer-sponsored plan, governmental plan, church plan, or a health benefit plan offered in conjunction with any of these plans. Certificates of creditable coverage must indicate at least 18 months of aggregate health insurance coverage.
- You have no more than a 63-day break in coverage.
- You have not been subject to a termination of COBRA coverage because of your failure to pay the required premium or because you committed fraud.

- I meet the six criteria listed above. *(Attach ALL Certificates of Creditable Coverage. If you cannot get a Certificate of Coverage, you can provide other written documentation from an employer or health plan that shows creditable coverage. Please call (866) 780-7105 for more details)*

### 3) Transfer from Another High-Risk Pool Coverage

**You are eligible for MHIP if:**

- You are a resident of the State of Maryland. *(Attach a copy of the front and back of your current Maryland driver's license or other recent documents showing your Maryland address, such as a voter registration card or utility bill in your name).*
- You are not enrolled or eligible for Medicare Part A or Part B, coverage under any employer-sponsored group health benefits plan, Medicaid, or Maryland Children's Health Insurance Program.

**AND**

- You have permanently moved to Maryland and are transferring from another state's high-risk pool.

State \_\_\_\_\_ Name of High Risk Pool \_\_\_\_\_

Identification No. \_\_\_\_\_

*(Attach Certificate of Creditable Coverage and a copy of your identification card. If you cannot get a Certificate of Coverage, you can provide other written documentation from the high-risk pool that shows creditable coverage. Please call (866) 780-7105 for more details.)*

## D. Certification of Eligibility (continued)

### 4) Trade Adjustment Assistance Act Coverage

**You are eligible for MHIP if:**

- You are a resident of the State of Maryland. (*Attach a copy of the front and back of your current Maryland driver's license.*)
- You are not enrolled or eligible for Medicare Part A or Part B, coverage under any employer-sponsored group health benefits plan, Medicaid, or Maryland Children's Health Insurance Program.

**AND**

**If ONE of the following applies:**

- You or your former employer have been certified by the U.S. Department of Labor as being affected by competition from foreign trade, and you are receiving either a Trade Readjustment Allowance under the Trade Adjustment Assistance program, or unemployment insurance benefits.
- You are a retiree aged 55 to 64 receiving pension payments from the Pension Benefit Guaranty Corporation.

*Note: Maryland Health Insurance Plan will use the above information to presume applicant eligibility for the Federal HealthCare Tax Credit. However, final determination of eligibility for the health care tax credit will be made by the federal government.*

If you qualify for MHIP under this category, MHIP is assuming you are eligible for a Federal Health Care Tax Credit (HCTC), which pays for 65% of the cost of your monthly MHIP premium. However, the federal government will make the final determination about eligibility for the HCTC. This premium credit will also apply to any dependents on your policy (spouse and/or children) if ALL of the following applies:

- None of your dependents are imprisoned;
  - None of your dependents are enrolled in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), or the Federal Employees Health Benefits Program (FEHBP);
- AND
- None of your dependents have insurance coverage provided by your spouse's employer where the employer pays 50 percent or more of the health insurance premiums.

ATTESTATION: I declare that, to the best of my knowledge and belief, my dependents meet the criteria listed above.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

## E. Personal & Insurance Eligibility Information

Completion of the following information is **required**. Income and marital status will not be used to determine eligibility. Data regarding other insurance or employer-based health benefits may be used for this purpose, based on statutory requirements. This data is compiled and used for evaluating future insurance market reform. **Please complete the following information for your total household income, whether or not other family members are enrolling in this plan. Your application cannot be processed without this information.**

**ARE YOU (check one):**    An employee    Self-employed    Not employed    Retired    Disabled

**ARE YOU (check one):**    Married    Single    Divorced    Widowed

Name of Employer (if employee or self-employed):		Street Address:		
City:		State:	Zip:	Your Occupation:
		No. of Employees (if known):		
<b>Yes</b>	<b>No</b>			
<input type="checkbox"/>	<input type="checkbox"/>	1. If you or your dependent(s) are employed, does your or your dependent(s)' employer offer health insurance to its employees?		
<input type="checkbox"/>	<input type="checkbox"/>	2. Are you or your dependent(s) covered under your employer's health plan? If "No", give reason: _____		
<input type="checkbox"/>	<input type="checkbox"/>	3. Have you or your dependent(s) ever been covered by your current employer's health plan? If "No", give reason: _____		
<input type="checkbox"/>	<input type="checkbox"/>	4. If your spouse is employed, does his/her employer offer health insurance for its employees? Spouse's Occupation: _____ Spouse's Employer: _____		
<input type="checkbox"/>	<input type="checkbox"/>	5. Are you currently covered under your spouse's employer's plan? If "No", give reason below: <input type="checkbox"/> Missed open enrollment time <input type="checkbox"/> Too expensive <input type="checkbox"/> Not available for dependents <input type="checkbox"/> Other: _____		
<input type="checkbox"/>	<input type="checkbox"/>	6. Have you or your dependent(s) been disabled for more than 1 year?		
<input type="checkbox"/>	<input type="checkbox"/>	7. Do you or your dependent(s) currently receive any type of long-term or short-term disability benefits? If "Yes", please explain the condition of disability: _____ _____		
<input type="checkbox"/>	<input type="checkbox"/>	8. Are you or any family member listed on this application currently eligible for any health benefit plan policy including Medicare or Medicaid or group coverage? If "Yes", specify what you/they are eligible for: _____ Name of Employer that offered the prior policy: _____		
<input type="checkbox"/>	<input type="checkbox"/>	9. How did you hear about the Maryland Health Insurance Plan? <input type="checkbox"/> Newspaper ad <input type="checkbox"/> Web site <input type="checkbox"/> Insurance producer <input type="checkbox"/> Doctor <input type="checkbox"/> Employer <input type="checkbox"/> Story in newspaper or on radio? Which one? _____ <input type="checkbox"/> Friend <input type="checkbox"/> Other		

**TOTAL ANNUAL GROSS HOUSEHOLD INCOME: (check one)**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> \$0 - \$12,120      | <input type="checkbox"/> \$25,001 - \$35,000 | <input type="checkbox"/> \$45,001 - \$55,000 | <input type="checkbox"/> \$65,001 - \$75,000 |
| <input type="checkbox"/> \$12,120 - \$25,000 | <input type="checkbox"/> \$35,001 - \$45,000 | <input type="checkbox"/> \$55,001 - \$65,000 | <input type="checkbox"/> \$75,001 or more    |

## *F. Affirmation Understanding*

I understand that I am applying to the Maryland Health Insurance Plan (MHIP) for an individual/family policy of medical, surgical, hospital and prescription coverage. I also understand that, following approval and acceptance of this application by MHIP, my coverage will become effective as follows:

If this application is received before the fifteenth of the current month, coverage will begin on the first of the next month;

If this application is received on or after the fifteenth of the current month, coverage will begin on the first of the following month (for example, if received on August 15th, coverage would be effective on October 1st).

I declare that, to the best of my knowledge and belief, the foregoing answers on the application are complete and correct. I understand that no coverage will be in effect until the full initial premium is paid after this application has been approved and accepted by MHIP.

1. If I have medical conditions that were diagnosed or treated in the six months immediately before I applied for coverage, I may be subject to a six-month pre-existing condition limitation, under which my MHIP policy will not cover the specific health conditions that existed before I applied for coverage. Pre-existing conditions will not be covered until my MHIP policy has been in effect for six months unless this pre-existing condition limitation period is not applicable.

\_\_\_\_\_ Initial here showing you have read the above paragraph.

2. If this application contains material misstatements or omissions, MHIP may do any or all of the following within two years from the date the policy was issued: a) cancel the agreement as though it was never effective and refund premiums, less any claims paid; b) retroactively deny benefits under the pre-existing condition exclusion period; or c) take any other action available to it by law. This time limit does not apply to fraudulent misstatements.

\_\_\_\_\_ Initial here showing you have read the above paragraph.

## **G. Insurance Producer Information - FOR PRODUCERS ONLY**

I, an Insurance Producer, have explained MHIP eligibility provisions to the applicant. I have made no statements of benefits, conditions, limitations or exclusions of the agreement except through written material furnished by MHIP. The applicant has been informed that coverage is not guaranteed, and if approved, is determined by the Maryland Health Insurance Plan.

**Insurance Producer signature certifies that the insurance producer has reviewed the application after it was completed and the application is complete and accurate. If the application is not complete and accurate, a referral fee may not be paid.**

Insurance Producer Name:	E-mail address:	Social Security Number:	
Insurance Producer Company Name:	Producer Lic. No.:	Tax I.D. No.:	
Street Address:	City:	State:	Zip:
Insurance Producer Signature:	Date:	Phone:	
Print Applicant's Name/Social Security Number:			

**Note: Insurance producer information must be complete to process the referral fee.**

## H. Applicant Signature and Disclosure Authorization

I authorize any medical professional, hospital, medical or medically related facility, pharmacy, government agency, insurance agency, health plan, or other person or firm to release my health information to Maryland Health Insurance Plan and its Plan Administrator, Maryland Physicians Care, or their agents. This includes information about my health insurance coverage, health insurance applications, Medicaid, Medicare or commercial insurance eligibility, residency, and medical record information, including information about communicable diseases and HIV/AIDS, mental health information, genetic information, and alcohol and drug treatment. This also includes information from other providers that are in the files of the recipient of this authorization.

This authorization is for the purpose of determining my enrollment or eligibility. If I sign this authorization, I may revoke the authorization at any time, unless my health information has already been released in reliance on the authorization. To revoke this authorization, I must submit a written request to the Plan Administrator's Privacy Officer. Unless I revoke this authorization earlier, it will expire one year from the date of my signature. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be redisclosed by the person or organization that receives the information. A photocopy of this authorization is as valid as the original.

_____ Applicant Signature	_____ Date
_____ Spouse Signature (if applicable)	_____ Date

## I. Premium Payment Information

To calculate your monthly premium, please refer to the premium rate cards included with this application or on the MHIP website at [www.marylandhealthinsuranceplan.state.md.us](http://www.marylandhealthinsuranceplan.state.md.us)

**Enclose payment for the first month's premium with this application. Hereafter, you will receive a monthly premium notice and payment is due the first of every month.**

**Robert L. Ehrlich, Jr.**  
*Governor*

**Michael S. Steele**  
*Lieutenant Governor*

**Maryland Health Insurance Plan**  
*Board of Directors*

**James C. DiPaula, Jr.**  
*Secretary*  
Department of Budget & Management

**Michael K. Hampton**  
Insurance Carrier Representative

**Brad Mainster, RHU**  
Insurance Producer representative

**Barbara Mc Lean**  
*Executive Director*  
Maryland Health Care Commission

**Robert Murray**  
*Executive Director*  
Health Services Cost Review Commission

**Karen Pollitz**  
Consumer Representative

**Alfred W. Redmer, Jr.**  
*Commissioner*  
Maryland Insurance Administration



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**MHIP Enrollment Department**  
**P.O. BOX 47160**  
**Baltimore, MD 21244-7160**