Illinois Preexisting Condition Insurance Plan (IPXP)
Eligibility and Enrollment Application

Each person applying for coverage must complete a separate application.
Throughout this application, the terms "you", "I" and "my" refer to the applicant.

Step 1: Applicant Information – Who is Applying for Coverage?

1. ______________ *first name* ______________ *middle name* ______________ *last name*

2. ______________ *residential address (P.O. Box or business address is not acceptable)* ______________ *maiden name (if applicable)*

   ______________ *city* ______________ *state* ______________ *zip code* ______________ *county*

3. ______________ *social security number* ______________ *birth date MM/DD/YYYY* ______ *age* ❑ Male ❑ Female

4. ______________ *home phone* ______________ *work phone* ______________ *cell phone*

5. Have you used tobacco within the past 12 months? ❑ Yes ❑ No

6. Marital Status: ❑ Single ❑ Married ❑ Civil Union ❑ Widowed ❑ Divorced/Separated
   Provide the date when widowed, divorced or separated. MM/DD/YYYY Date ______________

7. ______________ *spouse name (married or civil union)* ______________ *social security number*

8. ______________ *Custodial Parent/Guardian name if the applicant is a minor or is legally incompetent. If applicant is legally incompetent we require a copy of the legal guardianship documents.* ______________ *social security number*

9. Are you a U. S. Citizen? ❑ Yes ❑ No
   9a. If No, are you lawfully present in or a national of the U.S.? ❑ Yes ❑ No

10. Are you an Illinois resident? ❑ Yes ❑ No

11. ______________ *e-mail address (optional)* *To ensure that information is kept confidential, always encrypt e-mail transmissions.*

Step 2: Eligibility–How do you qualify for IPXP?

1. Have you been rejected or refused comprehensive coverage due to health reasons within the past 24 months?
   ❑ Yes ❑ No

2. Have you refused an offer of coverage from an insurance company or Health Plan within the past 24 months that has a rider that excludes coverage of your medical condition? (Please note that if you currently have insurance coverage that doesn't cover your medical condition, you are not eligible for IPXP.) ❑ Yes ❑ No

3. Have you refused an offer of coverage from an insurance company or health plan within the past 24 months that had a premium cost that was at least 125% of the standard rate for comparable coverage for such product in Illinois? (Please note that if you have had insurance coverage within the past 6 months, regardless of cost, you are not eligible for IPXP.)

4. If you answered "No" to questions 1, 2 or 3 do you have one of the presumptive medical conditions as outlined in the Summary of Coverage? ❑ Yes ❑ No

5. Identify your primary health condition: ______________
   Identify the primary health condition that prevents you from obtaining standard insurance coverage.

Step 3: Coverage Options

1. The IPXP Standard Plan features a $2000 calendar year deductible. You will be automatically enrolled in the Standard Plan unless you select the Extended Plan below. The Extended Plan features a $1000 calendar year deductible. Please see the Premium Rate Sheet to determine the difference in monthly premiums for the two options.

   I wish to be enrolled in the Extended Plan ❑ Yes ❑ No

2. How will the monthly premium be paid? ❑ recurring ACH debit or credit card ❑ monthly invoice
   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.

3. Who will be paying the premium? ❑ applicant/spouse *joint account* ❑ spouse *non-joint account* ❑ parent ❑ other

   If other, explain: ______________________________

Step 4: Most Recent Health Insurance/Health Plan Information

1. When was the last time you had health insurance coverage?
   ❑ less than 6 months ❑ 6 months to 1 yr ❑ greater than 1 year or never

2. When did or will this health insurance coverage end? ______________________________
   MM/DD/YYYY

   2a. Describe the type of health insurance coverage:
   ❑ 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 enrolled in Medicare? ❑ Yes ❑ No

5. Are you receiving or approved to receive 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 5: Illinois Insurance Producer Information

1. If a licensed Illinois insurance producer assisted with this application, provide the following information:

   Producer name: ______________________________ ______________________________
   First M Last *National Producer Number (NPN)*

   Agency Name ______________________________ FEIN ______________________________

   Address ______________________________
   City State Zip

   Area Code and Phone Number ______________________________ ______________________________
   Producer's Signature Date mm/dd/yy

2. By completing this section, you are authorizing IPXP to pay the insurance producer a referral fee. There is no contractual relationship between IPXP or its Plan Administrator with any insurance producer who may have helped you complete this application. A producer must be a licensed Illinois Accident and Health Insurance Producer and cannot be related to you or live with you to qualify for a referral fee.

____
Applicant's authorization and signature

3. Do you wish to authorize IPXP to discuss your application and eligibility with the above-named insurance producer? ❑ Yes ❑ No

4. If you answered yes, you agree to the following:
   - I authorize the release of any information which was submitted with my application, as well as all additional information related to my eligibility and enrollment determination, whether sent with my application or after my application was first received by IPXP.
   - This authorization for use/disclosure is solely for my application to IPXP.
   - This authorization will remain effective until 30 days following the final disposition of my application (approval, withdrawal, denial).
   - However, I understand that I have the right to revoke/withdraw this authorization, in writing, at any time, and that the revocation/withdrawal will be effective except to the extent that IPXP has already taken action in reliance on my authorization. My written statement that I want to revoke/withdraw my authorization should be delivered to the address in step 8.
   - I understand that this authorization is voluntary. Payment, enrollment or eligibility for benefits for my health care will not be affected if I do not sign this section of the form. Information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving this information. I should retain a signed and dated copy of this authorization form for my records. This authorization will expire upon the earliest of 30 days after: (i) my enrollment in IPXP; (ii) rejection of enrollment in IPXP; or (iii) withdrawal from consideration of enrollment in IPXP.

____

signature *date*

____

print name of applicant

Step 6: Required Documentation

1. To prove Illinois residency, attach a copy of your current valid Illinois driver's license (front and back), 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. Proof of lawful presence in the U.S.
   (a) If you are a U.S. Citizen, submit a certified copy of your birth certificate or a copy of your passport or certificate of naturalization.
   (b) If you are a U.S. Noncitizen National, submit a copy of a document that confirms your status as a noncitizen national, such as a copy of a U.S. passport that shows your national status.
   (c) If you, a noncitizen, submit a copy of your immigration documents, including at least one that has your Alien Registration Number or I-94 Number that will be used to verify your status.
   ❑ I-327 (Reentry Permit)
   ❑ I-551 (Permanent Resident Card)
   ❑ I-571 (Refugee Travel Document)
   ❑ I-766 (Employment Authorization Document)
   ❑ Machine Readable Immigrant Visa (with Temporary I-551 Language) affixed to Unexpired Foreign Passport
   ❑ Temporary I-551 Stamp (on passport or I-94) affixed to I-94 or Unexpired Foreign Passport
   ❑ I-94 (Arrival/Departure Record) with Unexpired Foreign Passport
   ❑ Unexpired Foreign Passport for Visa Waiver Program travelers
   ❑ I-20 (Certificate of Eligibility for Nonimmigrant [F-1] Student Status) accompanied by I-94 and an Unexpired Foreign Passport
   ❑ DS2019 (Certificate of Eligibility for Exchange Visitor [J-1] Status) accompanied by I-94 and an Unexpired Foreign Passport
   ❑ Other Document with an I-94 or Alien Number
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 dated within the past 24 months 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 dated within the last 24 months 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 dated within the past 24 months. (Your physician can complete the attached form instead); or

(c) a notice dated within the past 24 months to issue coverage but with a rider that does not cover your medical condition;or
(d) a noticed dated within the past 24 months to issue coverage but at a premium rate that is at least 125% of the standard rate for comparable coverage.

Step 7: Important Information

Do not send money with the application. We will contact you with additional information about premiums when processing of the application is complete. Premium rate tables can be found at www.insurance.illinois.gov or toll free at 1-877-210-9167.

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 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 will immediately notify IPXP:
  - of any health insurance coverage that I may get in the future.
  - if there is any chance in my employment or that of a family member's employment during the course of my enrollment in IPXP.
► 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? ❑ Yes ❑ No
Signed and dated the application? ❑ Yes ❑ No
Answered all questions completely? ❑ Yes ❑ No
Attached all documents as required? ❑ Yes ❑ No
Carefully read and reviewed all your answers to ensure their accuracy? ❑ Yes ❑ No

Step 8: Forward this Application and all documentation to:

Health Alliance Medical Plans
Attn: Illinois Preexisting Condition Health Insurance Plan
301 S. Vine St.
Urbana, IL 61801-3347
If you have questions you can call toll free at 1-877-210-9167 (TTY/TDD 866-883-8551).