Nebraska Comprehensive Health Insurance Pool

Administered by Coventry Health and Life Insurance Company
P.O. Box 541210 Omaha, NE 68154 | Phone: 855-247-5201 (Toll Free) | Fax: 866-799-9448 | www.nechip.com

APPLICATION FOR COVERAGE

Social Security Number	Name: (Last, First, Middle Initial, Title)	Date of Birth (Month, Day, Year)	☐ Male ☐ Female

Address: Street and/or P.O. Box City State Zip Code+4 County Length of time at present address:

PLAN ELECTION **Please Note:** Only changes to a higher deductible are allowed.

Calendar Year Deductible Options PPO/Non-PPO:

☐ $500/$1,000 ☐ $1,000/$2,000 ☐ $1,500/$3,000 ☐ $2,000/$4,000 ☐ $3,000/$6,000
☐ $4,000/$8,000 ☐ $5,000/$10,000 ☐ $7,500/$15,000 ☐ $10,000/$20,000 ☐ HSA – HDHP $2,000/$4,000

Maternity Endorsement ☐ Yes ☐ No
Are you a tobacco user? ☐ Yes ☐ No If no, read and sign the box below:

NON-TOBACCO USER CERTIFICATION STATEMENT

I certify that I neither presently smoke nor use tobacco products, nor have I smoked or used tobacco products (regardless of frequency) during the 12 months immediately preceding the date of this application. I understand that if my application is accepted, I will be entitled to a non-tobacco user discounted premium rate, and the Administrator will rely upon my application in determining my appropriate premium rate. **I understand that any misrepresentation of the information contained on this certification could result in denial of future claims or back payment of the tobacco-user premium rate from the effective date of CHIP coverage.**

Signature of Applicant _____ Date _____

Requested Policy Effective Date (choose one):

1. ☐ First of the month following receipt of application by Administrator (if received on the first of the month, date of receipt will be used).
2. ☐ Date of receipt of application by Administrator (one month premium plus partial month premium will be needed).
3. ☐ A date later than 1 or 2, above: _____
   Month Day Year

Exception: If you qualify for Pre-existing Condition waiver 2 or 3 (see page 3), your effective date will be the date following termination of prior coverage.

Premium Payment Method: ☐ Monthly Direct Bill ☐ Monthly Bank Debit

If Monthly Bank Debit is selected, please complete the following Debit Authorization section:

DEBIT AUTHORIZATION - I authorize NECHIP to initiate debit entries (charges) to my account indicated below and the Financial Institution named below to charge the said account.

Financial Institution	Town/City	Account Number ☐Checking ☐Savings

This authority is to remain in full force and effect until the Financial Institution has received written notification from me of its termination in such time as to afford the Financial Institution a reasonable opportunity to act on it. The initial authorization is for $_____ to be charged to my account on or after the 15th day of each month. Such amount may be changed from time to time by NECHIP giving me written notice before changing said amount. **ATTACH A VOIDED CHECK FOR OUR RECORDS.**

ALL QUESTIONS BELOW MUST BE ANSWERED OR YOUR APPLICATION WILL NOT BE PROCESSED.

- Are you covered by or eligible for Medicaid? ☐ Yes ☐ No
  If you are eligible for Medicaid, you are not eligible for CHIP.
- Have you been covered by Medicaid during the past 12 months? ☐ Yes ☐ No
  - If yes, when _____

- Are you covered by or eligible for Medicare? ☐ Yes ☐ No
  - If yes, did you qualify by reason of turning age 65? ☐ Yes ☐ No
    Please attach a copy of your Medicare card and Medicare's notice of eligibility.
    If you are eligible for Medicare based on age, you are not eligible for CHIP.

- Are you employed? ☐ Yes ☐ No
  - **If yes, Attachment B must be completed.**

- Is your spouse employed? ☐ Yes ☐ No ☐ N/A
  - **If yes, Attachment B must be completed.**

- If you are a dependent, is your parent/legal guardian employed? ☐ Yes ☐ No ☐ N/A
  - **If yes, Attachment B must be completed.**

- Do you have other insurance coverage? ☐ Yes ☐ No
  - If yes, name of company _____

- For females only: Do you have reason to believe you may now be pregnant? ☐ Yes ☐ No

Please Note: CHIP benefits shall be reduced by all amounts payable under any other health insurance or coverage

---

ELIGIBILITY CERTIFICATION #1: I certify that I am eligible for CHIP coverage as follows:

I have been a legal resident of Nebraska for at least six months; am not eligible for a group health plan, Medicaid or Medicare due to age; do not have other health insurance comparable to Pool coverage; am not eligible for, or have exhausted continuation coverage under COBRA or similar law, **and** (check ONE which applies to you):

☐ I have been rejected for other health insurance coverage due to reasons of health within the past six months. **(Attach a copy of the rejection letter.)**

☐ I have been refused health insurance coverage comparable to Pool coverage within the past six months. If you are a minor, you are deemed to have been refused coverage.

☐ I currently have, or was offered within the past six months, other health insurance coverage which includes a restrictive rider due to reasons of health. **(Attach proof of having or being offered such restrictive rider.)**

☐ I have been offered health insurance coverage comparable to Pool coverage, but at higher rates within the past six months. **(Attach a copy of the insurance offer showing higher rates. Include a copy of the Schedule of Benefits.)**

☐ I have been diagnosed with one or more of the medical conditions listed on the top of the next page. Please check all that apply. A letter from your physician with the physician's name, address, specialty or a signed prescription form with your name and exact diagnosis must accompany your application.

Medical Conditions (check all that apply)

- o AIDS / HIV
- o Addison's Disease
- o Alzheimer's Disease
- o Amyotrophic Lateral Sclerosis (ALS)
- o Aneurysm
- o Angina Pectoris
- o Aplastic Anemia
- o Arteriosclerosis Obliterans
- o Artificial Heart Valve
- o Attempted Suicide
- o Autism
- o Bipolar Disorder
- o Brain Tumors
- o Cardiomyopathy
- o Cerebral Palsy
- o Chemical Dependency (alcohol / drug abuse)
- o Cirrhosis of the Liver
- o Congestive Heart Failure
- o Coronary Artery Disease
- o Crohn's Disease
- o Cystic Fibrosis
- o Dementia
- o Diabetes (Type I or II)
- o Down's Syndrome
- o Emphysema / COPD
- o Epilepsy
- o Gastric Bypass Surgery
- o Hemophilia
- o Hepatitis, Chronic Active
- o Hodgkin's Disease
- o Hydrocephalus
- o Kidney Failure requiring Dialysis
- o Leukemia
- o Lupus
- o Major Depressive Disorder
- o Malignant Tumor (last 8 years)
- o Melanoma
- o Metastatic Cancer (last 8 years)
- o Multiple or Disseminated Sclerosis
- o Muscular Atrophy or Dystrophy
- o Myocardial Infarction
- o Open Heart Surgery
- o Pacemaker
- o Pancreatits
- o Paraplegia or Quadriplegia
- o Parkinson's Disease
- o Perpheral Vascular Disease
- o Progressive Systemic Sclerosis (Sclerdoerma)
- o Pulmonary Embolism
- o Rheumatiod Arthritis
- o Schizophrenia
- o Sickle Cell Anemia
- o Sleep Apnea
- o Tetralogy of Fallot
- o Transcient Ischemic Attack (TIA) / Stroke
- o Transplant Recipient

PRE-EXISTING CONDITIONS

The CHIP policy excludes coverage of pre-existing conditions for a period of six months, unless you qualify for one of the pre-existing condition waivers described below. **I apply for a Pre-existing Condition Waiver as follows:**

☐ **Pre-existing waiver #1 -** Prior Medicaid, Medically Handicapped Children's Program, Medicare.

This waiver is available if during the six month period immediately preceding the effective date of CHIP coverage: 1) you have received medical assistance through Medicaid or the Medically Handicapped Children's Program; or 2) you are an organ transplant recipient terminated from Medicare.

Please attach copy of appropriate document(s) to verify eligibility for this pre-existing condition waiver.

☐ **Pre-existing waiver #2 -** Involuntary Termination of Prior Coverage within the past 60 days.

My prior coverage terminated (date: _____) due to: (check appropriate box)

1) ☐ the withdrawal by the insurer from this state
2) ☐ the bankruptcy or insolvency of my employer or employer trust fund
3) ☐ the cessation by my employer of providing any group health plan for all of its employees.

I certify that I am not eligible for any conversion policy or continuation of coverage policy. **Please attach a letter of verification from either your employer or prior insurance carrier and a certificate of creditable coverage to document your eligibility.**

If you qualify for this waiver, the CHIP effective date shall be the date following the termination of prior coverage, and you are responsible for paying premium from that effective date. The CHIP pre-existing condition exclusion will be waived only to the extent that any similar exclusion was satisfied under your prior coverage.

☐ **Pre-existing waiver #3 –** Termination or Involuntary termination of a continuation of coverage policy available under state or federal law within the past 90 days**. Please attach a letter or other documentation from the employer or insurance carrier which indicates the termination date of COBRA or other such continuation of coverage policy.** If you qualify for this waiver, the CHIP effective date shall be the date following the termination, and you are responsible for paying premium from that effective date. The CHIP pre-existing condition exclusion will be waived only to the extent that any similar exclusion was satisfied under your prior coverage.

ELIGIBILITY CERTIFICATION #2: (Federally-eligible Individuals) **I certify that I am eligible for CHIP coverage as follows:**

☐ I am a legal Nebraska resident and meet all of the following requirements:

1) have an aggregate of at least 18 months of prior creditable coverage*, most recently under an employee group health plan, governmental or church plan;
2) am not eligible for a group health plan, Medicaid or Medicare due to age;
3) do not have other health insurance; and
4) am not eligible for, or have exhausted continuation coverage under COBRA or similar law.

*Creditable coverage does not include any coverage that occurs before a significant break in coverage. A significant break in coverage is any period of more than 62 days during which you did not have any creditable coverage.

Attach certificate(s) of prior creditable coverage and COBRA documentation.

PRE-EXISTING CONDITIONS

The CHIP policy excludes coverage of pre-existing conditions for a period of six months. If you are eligible for CHIP pursuant to this Eligibility Certification #2, this pre-existing condition waiting period will be waived.

ELIGIBILITY CERTIFICATION #3: I certify that I am eligible for CHIP coverage as follows:

☐ I am a legal Nebraska resident; am not eligible for a group health plan, Medicaid or Medicare due to age; do not have other health insurance comparable to Pool coverage; am not eligible for, or have exhausted continuation coverage under COBRA or similar law; and potentially eligible for the Health Coverage Tax Credit (HCTC) under the Trade Adjustment Assistance Reform Act of 2002. **Complete Attachment A.**

PRE-EXISTING CONDITIONS

The CHIP policy excludes coverage of pre-existing conditions for a period of six months. If you are eligible for CHIP coverage as a qualified trade adjustment assistance eligible individual, and have an aggregate of at least 3 months of creditable coverage as of the date of this application (without a significant break of more than 62 days), this pre-existing condition waiting period will be waived.

Premium payments are required on a monthly basis due on the first of each month. A check for the first monthly premium must be attached to this application. Also attach proof of Nebraska residency, e.g. rent receipts, state income tax return, house payment records, employment records, driver's license, etc.

I represent that my answers and statements on this application are true and complete to the best of my knowledge. I authorize my health care providers to furnish the CHIP Administrator with medical information to the extent necessary for processing claims. I understand that I must be, and remain a Nebraska resident to be eligible for CHIP coverage.

Applicant Signature _____ Date _____

Applicant Phone Number _____

Nebraska statute §44-4222 prohibits an insurer, agent, broker or third party administrator from referring an employee to the Pool, or arranging for an employee to apply for Pool coverage, for the purpose of separating that employee from group health coverage in connection with his or her employment.

AGENT USE ONLY (Please Print) *I represent that the answers and statements on this application are true and complete to the best of my knowledge.*

Name _____ Telephone Number _____

Street Address _____ City _____ State _____ Zip + 4 _____

Pay To _____ Pay to Tax ID _____

Signature _____ Date _____ State License # _____

Agency Name (if applicable) _ _____ Coventry Agent # _ _____
(leave blank if you have not been assigned one)

Attachment A

To be completed only by individuals potentially qualifying for the Health Coverage Tax Credit (HCTC) under the Trade Adjustment Assistance Reform Act of 2002

Please attach a copy of the HCTC Program Kit you received.

Name: _____ Date: _____

Eligibility Certification:

I certify that I am eligible for Comprehensive Health Insurance Pool (CHIP) coverage as follows:

1. ☐ I am a Nebraska resident;
2. ☐ I am potentially eligible for the Health Coverage Tax Credit available under the Trade Adjustment Reform Act of 2002; and
3. ☐ I am not:
    a. enrolled in a health plan maintained by an employer or former employer that pays (or I pay with pre-tax dollars) at least 50% of the cost of coverage;
    b. entitled to health care under Medicare Part A or enrolled in Medicare Part B;
    c. eligible for a state's Medicaid program;
    d. enrolled in a state's Children's Health Insurance Program (SCHIP);
    e. enrolled in a plan in the Federal Employee's Health Benefit Program (FEHBP);
    f. entitled to health coverage through the U.S. military health system;
    g. eligible to be claimed as a dependent on someone else's federal tax return; or
    h. imprisoned by a federal, state or local authority.

Premium payments are required on a monthly basis due on the first of each month. It is the applicant's responsibility to ensure timely payment of premium regardless of the status of the receipt of the Advance Tax Credit. Failure to pay premiums in a timely manner could result in termination of your coverage pursuant to the terms of your contract.

Applicant Signature: _____ Date: _____

Attachment B

NEBRASKA COMPREHENSIVE HEALTH INSURANCE POOL
EMPLOYER COVERAGE VERIFICATION FORM

This form is to be completed by you and your current employer and your spouse's current employer (even if your spouse is not covered or to be covered by the Pool). If the applicant is under the age of 25, single and eligible for coverage under a parent or step-parent, the current employer of each of the applicant's parents and/or step-parents (as applicable) must complete this form.

Individual's Information (SECTION A)	
Applicant Name:	Applicant Social Security Number
	Spouse's or Parent's Name (if applicable):
Applicant Signature	Date

Employer Information (To be completed and signed by current Employer only) (SECTION B)	
Employee's Name:	
Employer/Business Name:	Telephone Number:
Address:	Number of Employees (including owner if employed):
Date of Employee Hire or Business Start Date:	Waiting Period for Employer Health Coverage (if any):
How many hours a week does the employee usually work for your business?	

Do you provide group health plan coverage, either insured or self-insured? **o** Yes **o** No

Is the employee named above eligible for the group coverage? **o** Yes **o** No

If no, please explain:

Is coverage available for dependents of the employee? **o** Yes **o** No

Is the person, named above as the applicant (if other than employee), eligible for your coverage? **o** Yes **o** No

If no, please explain:

Name and telephone number of the insurance company:
Name of insurance company: _____
Telephone number: _____

Do you pay all or part of the cost of employee coverage for any employees? **o** Yes **o** No

If yes, please explain:

If you pay all or part of the cost for employee coverage, is the amount paid for insurance included in the employees' taxable wages? **o** Yes **o** No

If yes, can the employee use the amount paid for any other purpose? **o** Yes **o** No

If yes, please indicate the other permissible uses:

Do you pay for or reimburse or intend to pay or reimburse the person, named above as the employee, for all or part of the Pool premium, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan)? **o** Yes **o** No

Section B Continued on the Other Side

If you do not currently provide coverage, was coverage provided during the last 12 months? Date of and reason for coverage cancellation/termination:	**o** Yes **o** No
Do you intend to provide health coverage for employees in the next 6 months?	**o** Yes **o** No
Are you working with an agent or third party administrator to secure or establish group coverage?	**o** Yes **o** No
If yes, the name and telephone number of the agent or the TPA:	
I hereby certify that the above answers are true and correct. **I further understand that a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as the Nebraska Comprehensive Health Insurance Pool, for a person who is ineligible for such plan, is a violation of the anti-fraud provisions of the Health Insurance Portability and Accountability Act, 18 USC §1035, to which civil and criminal penalties, including imprisonment, can apply.**	
Employer's Signature: _____	Title: _____
Date: _____	Printed Name: _____