



Maryland Health Insurance Plan

Administered by CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.



# Enrollment Application Form

www.marylandhealthinsuranceplan.state.md.us

## 1. I am applying for (check plan option):

MHIP  MHIP and MHIP+

### If you are applying for MHIP:

- Check the MHIP benefit option for which you are applying on the first page of the MHIP application; and
- Complete the MHIP application (pages 1-7)

### If you are also applying for MHIP+:

- Complete the MHIP application (pages 1-7) and the MHIP+ application (pages 8-9)
- Check the MHIP+ benefit option for which you are applying on the MHIP+ application (pages 8-9);
- In the event that you do not qualify for MHIP+, check an MHIP benefit option on the first page of the MHIP application;

I want the following benefit option:

- HMO  
 PPO \$500 Deductible  
 PPO \$1,000 Deductible  
 PPO \$2,600 High Deductible

Please complete this form and return as indicated below:

By Mail : RxMom.com Insurance  
 MHIP Processing  
 3600 Saint Johns Ln  
 Suite D  
 Ellicott City MD 20142

Questions Phone (888)490-8782

## 2. Complete applicant information (must complete entire section). The oldest applicant is the policyholder.

If mailing address is different from home address, please attach mailing address.

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ E-Mail: (if available) \_\_\_\_\_

Name of Authorized Representative or Third-Party Payor: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

Third-Party Payer Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security Number

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Sex:  Male

Female

Date of Birth:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

If divorced, date of divorce:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

If married, is spouse employed?

Yes  No

Marital Status:  Married  Divorced  Single  Separated  Widowed

## 3. Indicate coverage type for which you are applying.

- Individual  Individual & Spouse  Individual & Child(ren)  Family

**4. Complete spouse/dependent/child information.**

(Complete ONLY if you want coverage for a spouse and/or dependents. Attach an additional sheet of paper, if necessary.)

Last Name	First Name	MI	Date of Birth	Soc. Sec. Number	Sex M/F	Spouse/Child S/C	Disabled Y/N
_____	_____	_____	__/__/____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	_____	__/__/____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	_____	__/__/____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	_____	__/__/____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> Y <input type="checkbox"/> N

**5. Indicate your employment status (must complete the entire section).**

- Employee   
  Self-employed   
  Receiving or applied for unemployment benefits  
 Retired   
  Disabled   
  Not employed

If not employed, date of last employment: \_\_\_\_\_

Work Phone Number:

If disabled, do you receive Social Security benefits?   
  Yes     No

(    ) \_\_\_\_\_

If yes, what date did your Social Security benefits begin: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Occupation:

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer health plan available to you through your current or former employer?   
  Yes     No

If yes, why are you not covered? \_\_\_\_\_

If no, why is it not available to you? \_\_\_\_\_

Spouse's or parent's employer health plan available to you through your spouse's or parent's current or former employer?

Yes    If yes, why are you not covered? \_\_\_\_\_

No    If no, why is it not available to you? \_\_\_\_\_

**6. You must complete ONE of the 5 sections below (A, B, C, D or E) that represents your eligibility category.**

(Check ALL BOXES within that category that apply). See the brochure for REQUIRED eligibility and residency documentation that must accompany your application.

**A. Medical Eligibility (Check one that applies)**

In addition to your proof of Maryland residency, you MUST attach letter from carrier showing denial, exclusionary rider or statement denoting higher premium than MHIP's due to a medical condition dated within the last six months.

- I have been denied individual health insurance in the last six months.
- I have, or have been offered, individual health insurance that excludes coverage of specific medical conditions due to my health conditions.
- I have, or have been offered, individual health insurance coverage with a premium rate that exceeds the MHIP premium for similar coverage due to my health condition.

**B. Health Condition Eligibility**

In addition to your proof of Maryland residency, you MUST include a letter from your physician confirming that you have been diagnosed or treated for one of the qualifying medical conditions listed in the brochure.

Please write below the medical condition from the list on page 4 of the brochure which applies to you. The condition you indicate MUST appear on the list AND must match exactly the physician's letter validating the condition.

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**C. Loss of Group Coverage-HIPAA (All four statements below MUST apply and be checked)**

Approved HIPAA applicants are not subject to the 6-month pre-existing condition waiting period.

In addition to your proof of Maryland residency, you MUST include a Certificate of Creditable coverage showing 18 months of continuous coverage from your carrier or refer to page 19 in the brochure, for a list of alternate documents.

- If available, I have elected and exhausted health benefits through COBRA or a similar state or federal continuation plan.
- I have 18 months of recent creditable coverage under a health plan, with my most recent coverage under an employer-sponsored, government or church plan.
- I have no more than a 63-day break in coverage.
- I have not been subject to termination of COBRA coverage because of failure to pay my premium or because of fraud.

**D. Transfer from another high risk pool (Both statements below MUST apply and be checked)**

In addition to your proof of Maryland residency, you MUST include a Certificate of Creditable coverage from your carrier or refer to page 20 of the brochure for a list of alternate documents, to not be subjected to the 6 month pre-existing condition waiting period.

- I have permanently moved to Maryland.
- I have transferred from another state high risk pool with no more than a 63-day break in coverage.

**E. TAA or PBGC Coverage – Health Coverage Tax Credit (HCTC) (Check all that apply)**

In addition to your proof of Maryland residency, attach a copy of your HCTC Eligibility Notice or recent PBGC Benefit Statement.

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

**Complete below ONLY if you are including a spouse or dependents on your policy.**

- My spouse or dependents are not imprisoned.  
AND
- My spouse and I are not covered under an employer's health plan that pays 50% or more of the cost of health coverage.

**7. Complete other health insurance information (REQUIRED).**

Are you enrolled in or eligible for (even if not enrolled) Medicare Part A or B, Medicaid Medical Assistance, or Maryland Children’s Health Program (MCHP)?  Yes  No

Are your spouse or your dependent(s) enrolled in or eligible for (even if not enrolled) Medicare Part A or B, Medicaid Medical Assistance or Maryland Children’s Health Program (MCHP)?  Yes  No

Are you, your spouse or dependent(s) enrolled in, or eligible for (even if not enrolled) any other individual or employer health plans, including COBRA?  Yes  No

Plan: \_\_\_\_\_ Policy # \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ From Date: \_\_\_\_\_ To Date: \_\_\_\_\_

You **MUST** complete this section below if you answered “Yes” to the questions above regarding other insurance information for you, your spouse or your dependent(s).

	Last Name	First Name	Insurance Plan	Policy Number	City	State	From Date	To Date
Applicant	_____	_____	_____	_____	_____	_____	_____	_____
Spouse	_____	_____	_____	_____	_____	_____	_____	_____
Dependent 2	_____	_____	_____	_____	_____	_____	_____	_____
Dependent 3	_____	_____	_____	_____	_____	_____	_____	_____
Dependent 4	_____	_____	_____	_____	_____	_____	_____	_____

**8. HMO applicants ONLY - Indicate the Primary Care Physician (PCP) selections for yourself, spouse and dependents (If applicable).**

	Last Name	First Name	MI:	Primary Care Physician (PCP) Provider Listing	Existing Patient of the PCP?
Applicant	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 2	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 3	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 4	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**9. Health questionnaire**

**ALL applicants must complete the following health questionnaire.**

If you were previously uninsured for more than 63 days, then you may have to wait for a certain period before coverage is provided for charges associated with any pre-existing medical condition(s). Pregnancy is not subject to the pre-existing condition waiting period. You will be responsible for paying plan premiums during this period.

If you had previous health coverage within 63 days of applying for MHIP, the six month pre-existing condition waiting period will be reduced for the period of time you were covered under prior coverage. To be credited for prior coverage, you must return certificates of coverage from your prior health carrier or plan that documents prior health coverage for yourself and/or your covered dependents. If you cannot get a certificate of coverage from your prior health plan, you can prove that you have prior coverage by providing any of the following:

- Correspondence from your prior health plan
- Pay stubs or check payments showing payments for health insurance
- Health insurance identification card showing effective and termination dates
- Medical records showing health coverage or
- Third party statements verifying the coverage

PLEASE COMPLETE SECTIONS A, B, AND C BELOW. CHECK EACH ITEM “YES” OR “NO.” ALL QUESTIONS MUST BE ANSWERED.

SECTION A – If any person included in this application is presently using medication or prescription drugs, please provide the following information.

Name of Family Member	Illness or Condition	Date of Last Treatment	Operation (Yes or No)	Medication Prescribed	Attending Physician Name and Address

SECTION B – To the best of your knowledge and belief, has any person named on this MHIP application, had within the last six months, or does such person now have, any of the following:

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Cancer, tumor or other growth (malignant or benign) .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus Seropositivity (Positive HIV test).....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Kidney stones, kidney or bladder condition, urinary frequency or burning.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Goiter, thyroid condition, diabetes .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Seizure disorder, central nervous system disorder, multiple sclerosis.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Substance abuse (drug or alcohol dependency, abuse or addiction) .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Use of illicit drugs .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Cataract or other eye condition .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Tuberculosis, lung condition, asthma, bronchitis .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Arthritis, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Heart condition, abnormal blood pressure (hypertension or hypotension), rheumatic fever, cerebrovascular accident (stroke) .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. (Female) Irregular or excessive menstrual bleeding, reproductive system disorders, infertility, breast condition.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. (Male) Prostate condition, reproductive system disorders, infertility.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Outpatient counseling, any psychiatric or psychological counseling, or any nervous or mental disorder .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Sexually transmitted diseases.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Anemia, blood disorders.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Excluding physical examinations, consulted a physician, health care provider, or other individual or facility for medical or surgical treatment, advice, screening for any condition, or prescription medication for a medical condition NOT listed above in items 1-17?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Had any departure from good health not previously mentioned in this questionnaire for which treatment or advice has been sought? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

**NOTE:** ALL QUESTIONS MUST BE CHECKED “YES” OR “NO” – OR YOUR APPLICATION WILL BE RETURNED. FAILURE TO DISCLOSE CONDITIONS MAY RESULT IN DELAY OF CLAIM PROCESSING UNDER THE PLAN.

SECTION C – If you have checked “YES” to any part of SECTION B, for each box checked, please provide complete information regarding diagnosis or condition, treatment (including all medications, hospitalizations, surgeries and diagnostic testing results) and dates. If more space is needed, attach a separate sheet of paper.

Name of Family Member	Question Number	Diagnosis or Condition	Duration Dates <i>Fechas de duración</i>	Explain treatment including all medications, hospitalizations, surgery and diagnostic test results and physician’s/hospital’s name.	Recovery (Check only one box.)
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM TO		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL
			FROM: TO:		<input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL

NOTE: FAILURE TO DISCLOSE CONDITIONS MAY RESULT IN DELAY OF CLAIM PROCESSING UNDER THE PLAN.

**10. Indicate total annual household income including wages, Social Security, investment income, alimony etc. (Check one)**

- \$0 – \$12,490     
  \$25,001 – \$35,000     
  \$45,001 – \$55,000     
  \$65,001 – \$75,000  
 \$12,491 – \$25,000     
  \$35,001 – \$45,000     
  \$55,001 – \$65,000     
  \$75,001 or more

**11. How did you hear about the Maryland Health Insurance Plan (MHIP)?**

- Newspaper     
  Insurance producer     
  Employer     
  Radio/TV     
  Insurance company  
 Website     
  Doctor     
  Friend     
  Health Organization     
  Other

**12. Agreement to terms and release of information**

I declare that, to the best of my knowledge and belief, the foregoing answers on the application are true, accurate and 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. If this application contains material misstatements or omissions, MHIP may do any or all of the following within 2 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 for pre-existing conditions during the pre-existing exclusionary period;
- c) Take any other action available by law. This time limit does not apply to fraudulent misstatements.

I authorize my medical professional, hospital, medical or medically related facility, pharmacy, government agency, insurance agency, health plan, other person or firm, or any government agency to release my health and eligibility information to Maryland Health Insurance Plan and its Plan Administrator, CareFirst BlueCross BlueShield, or their agents. This includes information about my health insurance coverage, health insurance applications, Medicaid, Medicare or commercial insurance eligibility, residency, medical record 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.

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 pre-existing condition limitation, under which my MHIP policy will not cover the specific health conditions that existed before I applied for coverage. Pregnancy is not a pre-existing condition. Pre-existing conditions will not be covered until my MHIP policy has been in effect for a period specified in the MHIP Certificate of Coverage for the plan year when I first enroll, unless this pre-existing condition limitation period is not applicable.

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 for the release of medical information. Unless HIPAA-eligible, I agree to accept the effective date that is determined based on the date that my completed application is received by MHIP in accordance with the Certificate of Coverage.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If subject to the pre-existing condition waiting period, do you want to "buy down" the pre-existing condition waiting period by paying additional premium (see pages 11-13 and 16 of brochure)? **NOTE: If you elect to not "buy down" the pre-existing condition waiting period at this time, you may not do so later.**  Yes  No

Spouse Signature (If applicable): \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Representative, Parent or  
Legal Guardian Signature (If applicable): \_\_\_\_\_ Date: \_\_\_\_\_

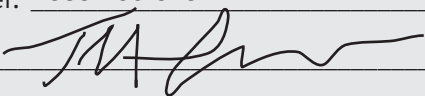
**FOR INSURANCE PRODUCERS ONLY**—I, an Insurance Producer, have explained MHIP eligibility provisions to the applicant. I have made no statements of benefits, conditions, limitations, or exclusions of the agreement except through written material furnished by MHIP. The applicant has been informed that coverage is not guaranteed, and if approved, is determined by the Maryland Health Insurance Plan. My signature certifies that I have reviewed the application after it was completed and the application is complete and accurate. I understand that if the application is not complete and accurate, the referral fee may not be paid. Send broker applications to: **10455 Mill Run Circle, Owings Mills, MD 21117, Attn: Broker Sales - Mail Stop 01-415**

Insurance Producer Name: Thomas Musembi

Tax ID #: 26-3960 663

License #: RPF 100011933 Expiration Date: 01/04/2011

Phone Number: 888-490-8782

Signature:  Date: \_\_\_\_\_

Company Name: RxMom.com Insurance Company Address: 3600 St Johns Ln Suite D Ellicott City MD 21042

### MHIP+ Application

MHIP members who have an annual income at or below certain levels are eligible for reduced premiums and lower initial deductibles. The level of annual savings from lower premiums and deductibles can be as high as \$6,500. In order to qualify, the total household income must be at or below the following levels, which vary by the size of your household:

Household Size*	MHIP+ Income Eligibility	Household Size*	MHIP+ Income Eligibility
1	\$32,490	5	\$77,370
2	\$43,710	6	\$88,590
3	\$54,930	7	\$99,810
4	\$66,150	8	\$111,030
<b>Larger than 8, call MHIP Sales Center at (443) 738-0667 or (888) 444-9016</b>			

\*Your household size is the total number of exemptions claimed on your tax return and is not related to the total number of individuals on your MHIP policy or application.

**If you believe your income is at or below the above amounts, we recommend you complete this form by answering the questions below, attach the required additional MHIP+ documentation and submit it with your MHIP application.**

1. Please list the total number of exemptions claimed on your 2008 tax return filed for your household: \_\_\_\_\_
2. Please list the total number of individuals currently in your household: \_\_\_\_\_
3. Please tell us about your yearly household income as reflected on your 2008 tax return. If you are married, your spouse lives in your household, and you did not file a joint tax return that year, complete columns A, B and C.

	<b>A</b> <u>Your Return</u>	<b>B</b> <u>Spouse's Return</u>	<b>C</b> <u>Total</u>
<input type="checkbox"/> Filed a 1040, the total household income listed on line 22:	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Filed a 1040, non-taxed Social Security income listed on line 20a minus 20b:	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Filed a 1040EZ, the adjusted gross income on line 4:	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Filed a 1040A, the total household income listed on line 15:	\$ _____	\$ _____	\$ _____
<input type="checkbox"/> Filed a 1040A, non-taxed Social Security income listed on line 14a minus 14b:	\$ _____	\$ _____	\$ _____
4. Total combined household income listed above* (amount listed in number 3, Column C above):			\$ _____
5. Please tell us what you believe your yearly household income will be this year:			\$ _____

6. Please check the plan requested (refer to the brochure for rates, benefits and qualifications):

**PPO \$200:**     Plan 1     Plan 2            **PPO \$500:**    Plan 3     Plan 5            **HMO:**     Plan 4     Plan 6

<b>MHIP+ Plan Option Chart (see pages 6, 12-14 of brochure for information on premiums and benefits)</b>				
Household Size	Plan 1	Plan 2	Plan 3 or 4	Plan 5 or 6
1	\$0 - \$16,245	\$16,246 - \$21,660	\$21,661 - \$27,075	\$27,076 - \$32,490
2	\$0 - \$21,855	\$21,856 - \$29,140	\$29,141 - \$36,425	\$36,426 - \$43,710
3	\$0 - \$27,465	\$27,466 - \$36,620	\$36,621 - \$45,775	\$45,776 - \$54,930
4	\$0 - \$33,075	\$33,076 - \$44,100	\$44,101 - \$55,125	\$55,126 - \$66,150
5	\$0 - \$38,685	\$38,686 - \$51,580	\$51,581 - \$64,475	\$64,476 - \$77,370
6	\$0 - \$44,295	\$44,296 - \$59,060	\$59,061 - \$73,825	\$73,826 - \$88,590
7	\$0 - \$49,905	\$49,906 - \$66,540	\$66,541 - \$83,175	\$83,176 - \$99,810
8	\$0 - \$55,515	\$55,516 - \$74,020	\$74,021 - \$92,525	\$92,526 - \$111,030



MHIP  
Maryland Health Insurance Plan

CareFirst   
BlueChoice.

CareFirst   
BlueCross BlueShield

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