Maryland Health Insurance Plan

From the CareFirst BlueCross BlueShield family of health care plans.

Administered by CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.
10455 Mill Run Circle, RR-380
Owings Mills, MD 21117- 9685

MHIP Standard Application

www.marylandhealthinsuranceplan.state.md.us

SECTION 1: Complete all applicant information.

Applicant's Name Last	First		Middle	
Social Security Number	Gender	Age	Date of Birth	
Primary Phone	Secondary Phone		Email Address	
Home Address				
City	County		State	Zip Code
Mailing Address (if different than listed above)				
City	County		State	Zip Code

SECTION 2: Complete if payments will be made by an authorized representative or third party payor.

Name Last		First	
Relationship	Primary Phone	Email Address	
Address			
City	County	State	Zip Code

SECTION 3: Indicate marital status.

❒ Married ❒ Divorced ❒ Single ❒ Separated ❒ Widowed

SECTION 4: Select coverage type.

❒ Individual ❒ Individual & Spouse ❒ Individual & Children ❒ Family

SECTION 5: List Spouse and/or Dependents to be insured. Attach an additional sheet of paper, if necessary. PLEASE NOTE: If you are applying only to MHIP Federal, do not complete this section. MHIP Federal *does not* provide coverage for spouses or dependents.

Last Name	First Name	M. I.	Date of Birth day / month / year	Social Security Number	Gender M / F	Spouse/Child S / C	Disabled Yes/No
			____ /____ /______		❒ / ❒	❒ / ❒	❒ / ❒
			____ /____ /______		❒ / ❒	❒ / ❒	❒ / ❒
			____ /____ /______		❒ / ❒	❒ / ❒	❒ / ❒
			____ /____ /______		❒ / ❒	❒ / ❒	❒ / ❒

SECTION 6: Indicate the program for which you are applying, and the option of your choice.
PLEASE NOTE: You may also be eligible for a reduced premium. See pages 16-17 of the Enrollment Guide for more information.

❐ **MHIP Federal (Individual coverage only)** Complete pages 1-7 and the MHIP Federal Application on page 8. ❐ HDP (PPO) $1,500 combined deductible	❐ **MHIP Standard** Complete pages 1-7. ❐ PPO $500 medical deductible ❐ PPO $1,000 medical deductible ❐ HMO ❐ HealthyBlue Triple Option ❐ HDP $2,600 (combined deductible)

SECTION 7: Indicate employment status.

❐ Employee	❐ Self-Employed	❐ Receiving, or applied for, unemployment benefits
❐ Retired	❐ Disabled	❐ Not employed. Date of last employment: ____ /____ /______

Employer Name	Phone number	
Address	City	State

If married, indicate spouse's employment status:

❐ Employee	❐ Self-Employed	❐ Not employed	❐ Retired	❐ Receiving, or applied for, unemployment benefits

Employer's Name	Phone number	
Address	City	State

SECTION 8: HMO and HealthyBlue 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					❑ Yes	❑ No
Spouse					❑ Yes	❑ No
Dependent 2					❑ Yes	❑ No
Dependent 3					❑ Yes	❑ No

SECTION 9: Access to health insurance.

If employed, is health insurance offered by your employer?	❐ Yes ❐ No
Are you eligible?	❐ Yes ❐ No
If you are eligible and not enrolled, why not? (N/A is not an acceptable answer)	
If you are not eligible, why not? (N/A is not an acceptable answer)	
If you are a child, are you able to enroll on your parent(s)' policy or policies? ❐ Yes ❐ No	
If you are disabled, specify your disability dates:	From ____ /____ /______ To ____ /____ /______
As part of your disability, are you eligible or receiving health insurance benefits? ❐ Yes ❐ No	

▶ **Attach a copy of your disability award letter from Social Security or other insurance plan.**

SECTION 10: Complete other health insurance information (REQUIRED).

Are you enrolled in, or eligible for, Medicare Part A or B, Medicaid Medical Assistance, or Maryland Children's Health Program (MCHP)? ❒ Yes ❒ No

Is your spouse or are your dependent(s) enrolled in, or eligible for, 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, any other individual or employer health plans, including COBRA? ❒ Yes ❒ No

If you are eligible, why are you not enrolled? ______________________________

You MUST complete the section below if you answered "Yes" to any of the questions on the previous page regarding other insurance information for you, your spouse or your dependent(s). Attach an additional sheet of paper, if necessary.

	Last name	First name	Insurance Plan	Policy #	City	State	From Date	To Date
Applicant								
Spouse								
Dependent 2								
Dependent 3								

SECTION 11: There are a variety of ways that you may qualify for coverage through MHIP. Review these options and complete the appropriate section 11A - 11D below.

Medically Eligible	(a) You were denied coverage for medical reasons within the last six (6) months. (b) You are enrolled in, or have the opportunity to enroll in, a health insurance plan that: • Limits, restricts or blocks your coverage for a specific medical condition; or • Has benefits that are similar to MHIP, but costs you more due to your medical condition. (c) You have one of the medical conditions listed on page 4 of the Enrollment Guide. **Complete SECTION 11A — Medically Eligible**
HIPAA Eligible	You recently lost group coverage and have exhausted COBRA or other continuous coverage and you do not have more than a 63-day break in coverage. **Complete SECTION 11B — HIPAA Eligible**
High Risk Pool Transfer	You are transferring from another state High Risk Pool. **Complete SECTION 11C — High Risk Pool Transfer Eligible**
Health Coverage Tax Credit	You qualify for the Health Coverage Tax Credit (HCTC). For this coverage, the applicant or a family member must have a HCTC certification from the federal government. **Complete SECTION 11D — HCTC Eligible**

SECTION 11A — Medically Eligible

Complete this section if you are Medically Eligible. Determine your Medically Eligible category by checking the appropriate box below.

❒ I have been denied individual health insurance in the last six (6) months.
▶ **Attach a copy of your denial letter from the insurance carrier dated with the last six (6) months.**

❒ I have, or have been offered, individual health insurance that permanently excludes coverage of a specific medical condition.
▶ **Attach a copy of the document that excludes your medical condition from coverage.**

❒ 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 medical condition.
▶ **Attach a copy of the benefit summary from your insurance carrier.**

❒ I have a qualifying medical condition(s) listed on page 4 of the Enrollment Guide.

My qualifying medical condition(s) is: ______________________________

▶ **Attach a letter from your physician on their letterhead, including physician's license number and signature, confirming that you have been diagnosed or treated for the specific qualifying medical condition listed above.**

SECTION 11B — HIPAA Eligible

Complete this section if you are HIPAA Eligible.

(a) Check all boxes below that apply.

- ❒ If available, I have elected and exhausted health care benefits through COBRA or a similar state or federal continuation plan.
- ❒ I have a total of 18 months or more of creditable coverage under a health care plan and my most recent coverage was under an employer-sponsored, governmental 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.

(b) With regard to your most recent prior health care coverage, provide the reason why coverage was terminated.

- ❒ End of COBRA/continuation period
- ❒ Business closed/bankruptcy
- ❒ Cancellation/non-renewal by issuer
- ❒ Employer terminated Group Health Plan
- ❒ Other reason: specify: ______________________________

▶ **Attach supporting documentation from your employer or insurance carrier as verification.**

(c) Dates of COBRA From ____ /____ /______ To ____ /____ /______

▶ **Attach a copy of your Certificate of Creditable Coverage showing beginning and ending dates of coverage and why your coverage ended.**

SECTION 11C — High Risk Pool Transfer Eligible

Complete this section if you are High Risk Pool Transfer Eligible.

❒ I have permanently moved to Maryland.

❒ I have transferred from another high risk pool with no more than a 63-day break in coverage.

▶ **Provide a copy of your Certificate of Creditable Coverage from the insurance carrier showing beginning and ending dates of coverage.**

SECTION 11D — HCTC Eligible

Complete this section if you are HCTC Eligible. This includes TAA or PBGC coverage.

▶ **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.

SECTION 12: Complete health questionnaire (REQUIRED).

If you were previously uninsured for more than 63 days, you may have to wait before coverage is provided for charges associated with any pre-existing medical condition(s). You will be responsible for paying plan premiums during this period.

Alternatively, you may have had previous health care coverage within 63 days of applying for MHIP. If this is the case, the six (6) month pre-existing medical condition waiting period will be reduced for the period of time you were covered under prior health care coverage. To be credited for prior health care coverage, you must return a certificate of coverage form from your prior health care carrier or plan that documents your prior health care coverage for you and/or your covered dependents. If you cannot obtain a certificate of coverage from your prior health care plan, you may provide any of the following:

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

NOTE: Pregnancy is not subject to the pre-existing medical condition waiting period.

COMPLETE SECTIONS A AND B BELOW. ALL QUESTIONS MUST BE CHECKED "YES" OR "NO" OR YOUR APPLICATION WILL BE RETURNED. FAILURE TO DISCLOSE CONDITIONS MAY DELAY THE PROCESSING OF YOUR CLAIMS.

SECTION A — To the best of your knowledge, information and belief, has any person named on this MHIP application, had within the last six (6) months, or does such person now have, any of the following:

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

SECTION 12: Complete health questionnaire (REQUIRED). (continued)

SECTION B — If you checked "YES" to any part of SECTION A, 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	Explain treatment, including all medications, hospitalizations, surgery and diagnostic test results and physician's/hospital's name(s).	Recovery (Check only one box)
			FROM: TO:		❐ Full ❐ Partial
			FROM: TO:		❐ Full ❐ Partial

NOTE: FAILURE TO DISCLOSE CONDITIONS MAY DELAY THE PROCESSING OF YOUR CLAIMS.

SECTION 13: Indicate your gross annual household income, including wages, Social Security, investment income, alimony, etc. (Check one)

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

SECTION 14: Indicate how you heard about the Maryland Health Insurance Plan (MHIP).

❐ MHIP Website
❐ Online search or ad
❐ Facebook/Twitter
❐ Radio/TV
❐ Event
❐ Health Organization
❐ Insurance Company
❐ Friend or Family
❐ Doctor
❐ Broker
❐ Bus/Poster/Billboard
❐ Other _______________

SECTION 15: Agreement to terms and release of information.

A. I, the undersigned, do hereby certify that the information contained on this application is true and accurate to the best of my knowledge, information and belief. I understand that coverage will not go into effect unless and until the full initial premium is paid and received following the approval of this application and acceptance by MHIP. I acknowledge that MHIP may take any or all of the following actions if it is determined that this application contains false or misleading information and omissions of requested information:

1. MHIP may cancel the agreement to provide health care coverage as though it was never effective and refund premiums less claims paid;
2. MHIP may retroactively deny benefits for pre-existing medical conditions during the pre-existing exclusionary period;
3. MHIP may take any action or seek any remedy available by law. Actions taken or remedies sought as a result of fraudulent misstatements are not time barred.

B. I do hereby authorize my treating medical professionals, hospitals, facilities, pharmacies, insurance agencies, health plans, other people or firms, or any government agency to release my health and eligibility information to MHIP and its Plan Administrator, CareFirst BlueCross BlueShield, or their agents, representatives or assigns. I further authorize the aforementioned individuals and entities to release information related to my health insurance coverage, health insurance application(s), Medicaid, Medicare or commercial insurance eligibility, residency, medical records, genetics, alcohol and drug treatment. I further authorize the release of information in the files of the recipient of this document from other providers.

I acknowledge that this authorization is for the purpose of determining my enrollment and/or eligibility for the Plan. This authorization may be revoked at any time unless information has already been released pursuant to this authorization. To revoke this authorization, I acknowledge that I must submit a written request to the Plan Administrator's Privacy Officer. Unless otherwise revoked, this authorization will expire one (1) year from the date of my signature below. I understand that if information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the individual or entity that received the information. A photocopy of this authorization is as valid as the original for purposes of authorizing the release of information. Unless HIPAA-eligible, I accept the effective date of coverage as determined by the date the completed application is received by MHIP and in accordance with the Certificate of Coverage.

SECTION 15: Agreement to terms and release of information. (continued)

I acknowledge that I may be subject to a pre-existing medical condition limitation under which the MHIP policy may not cover the specific medical condition(s) that existed prior to my application for coverage if I have a medical condition that was diagnosed and/or treated in the six (6) months immediately before I applied for coverage under the Plan. I acknowledge that pregnancy is not a pre-existing medical condition. A pre-existing medical condition will not be covered under the Plan until my MHIP policy has been in effect for a period specified in the MHIP Certificate of Coverage for the plan year during which I first enroll, unless the pre-existing medical condition limitation period is otherwise inapplicable.

C. If subject to the pre-existing medical condition waiting period, do you want to purchase the option to “buy down” the pre-existing medical condition waiting period by paying an additional premium? ❐ Yes ❐ No

NOTE: If you elect NOT to “buy down” the pre-existing medical condition waiting period at this time, you may NOT do so later.

I acknowledge that a medically underwritten health insurance policy is issued under the requirement that the health conditions of all persons named on the application remains as stated in the application. I acknowledge that failure to provide accurate, complete, current medical information may result in the denial of all benefits or cancellation of the policy. I acknowledge that MHIP may terminate, rescind or void coverage if: (1) I have committed fraud or (2) I intentionally misrepresented information. I acknowledge that MHIP reserves the right to terminate a policy pursuant to the terms and conditions set forth in the Certificate of Coverage. In the event coverage is terminated, I acknowledge that I may be responsible for the repayment of certain claims made by MHIP on my behalf. I acknowledge that I am solely and completely responsible for updating MHIP if the health condition of any person named on this application changes prior to acceptance of this application by MHIP.

If you have any questions concerning the benefits and services provided or excluded by the MHIP Plans, please contact a membership services representative before signing this application.

Applicant Signature: ______________________________ Date: ______________

Spouse Signature: ______________________________ Date: ______________

Authorized Representative, Parent or
Legal Guardian Signature (If applicable): ______________________________ Date: ______________

Make complete copies of your documentation before submitting, for your records. Original documents will NOT be returned to you. Mail your MHIP application form and all required documents to: MHIP, 10800 Red Run Blvd, Mail Stop 380, Owings Mills, MD 21117.

FOR INSURANCE PRODUCERS ONLY — I, an Insurance Producer, have explained the MHIP eligibility provisions to the applicant. I have made no statements of benefits, conditions, limitations, or exclusions of the agreement except through written materials furnished by MHIP. The applicant has been informed that coverage is not guaranteed and, if approved, is determined by MHIP. My signature certifies that I have reviewed the application after it was completed and the application is complete and accurate to the best of my knowledge, information and belief. 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.
In order for compensation to be remitted, you must have a valid Form W-9 on file.

Insurance Producer’s Name (please print)		
License #	Expiration date	Phone Number
Signature		Date

To direct payment to agent, please complete this section: (This information must match your Form W-9)

Insurance Producer’s SSN	Producer’s Address

OR

To direct payment to the company, please complete this section: (This information must match your Form W-9)

Company Name	Tax ID
Company Address	

MHIP Federal Application

If you have a medical condition and you have been without health insurance for six (6) months, you may be eligible for MHIP Federal, which allows you to get immediate coverage for your medical condition(s). In addition to completing the MHIP Standard Application, you will need to complete the MHIP Federal Application. Refer to the MHIP Enrollment Guide for eligibility requirements.

Section 1. Verification of Citizenship or Lawful Presence

Check one of the following:

❏ I am a citizen of the United States

❏ I am lawfully present in the United States

As proof of citizenship, attach one of the following with this application:

- A certified copy of a birth certificate filed with the State Office of Vital Statistics or equivalent agency in your state of birth within the United States (including the District of Columbia and a possession, territory or commonwealth of the United States);
- A copy of a valid, unexpired U.S. passport;
- A copy of a Consular Report of Birth Abroad (CRBA) issued by the U.S. Department of State; or
- A copy of a Certificate of Naturalization issued by the U.S. Department of Homeland Security or a predecessor agency.

As proof of lawful presence, attach one of the following with this application:

- A copy of a valid, unexpired Permanent Resident Card issued by the U.S. Department of Homeland Security;
- A copy of unexpired employment authorization documents (EAD) issued by the U.S. Department of Homeland Security; or
- A copy of an unexpired foreign passport with a valid, unexpired U.S. visa affixed accompanied by the approved I-94 form documenting your most recent admittance into the U.S.

Section 2. Verification of No Health Insurance for the Past Six (6) Months

❏ I have not had health insurance for a continuous six (6) month period of time immediately prior to the date of this application.

Section 3. Federal High Risk Pool Transfer

❏ Check this box if you are transferring coverage from another Federal High Risk Pool plan and have permanently moved to Maryland.

Section 4. Certification and Signature

I, the undersigned, do hereby certify that the information contained on this application is true and accurate to the best of my knowledge, information and belief. I authorize MHIP to take any and all steps necessary to verify the information provided in this application. The information provided will be used to confirm my eligibility for the MHIP Federal program and may not be disclosed to parties other than MHIP. I acknowledge that I may be subject to a penalty for knowingly providing false, misleading or inaccurate information. I understand that I may be required to provide additional information. By virtue of executing this certification and completing this application for membership in the temporary federal high risk pool, I hereby consent to the release of information by the state or federal authorities regarding my citizenship, lawful presence in the United States, and any and all prior health insurance coverage.

Print Applicant Name ______________________________

Signature of Applicant ______________________________ Date ______________

Print Name of Parent or Legal Guardian ______________________________

Signature of Parent or Legal Guardian ______________________________

If Applicant is Under Age 18 or Legally Incompetent

MHIP Subsidy Application For

MHIP+ and MHIP Federal+

MHIP applicants with qualifying incomes are eligible for reduced premiums. To qualify, total income from all sources must be considered. Household income is defined as the sum of income received in the calendar year by all household members 15 years old and over, including household members not related to the householder. Included in the total income are amounts reported separately for wage or salary income, unemployment compensation, self-employment income, interest, dividends, rental income, income from estates and trusts, Social Security or Railroad Retirement income, Supplemental Security Income (SSI), public assistance or welfare payments, retirement, survivor, or disability pensions, and all other income.

1. List the total number of individuals residing in your household that cannot be claimed as a dependent on your tax return _______________.

2. List the names from question 1 and their total income from all sources. (Attach additional pages, if necessary)

   Name: ___________________________ Total Income: ________________________________

   Name: ___________________________ Total Income: ________________________________

3. Do you or anyone else living in your household receive Social Security Income, Railroad Retirement Income, Supplemental Security Income, Workers Compensation, Child Support or Non-SSI Disability Income? ❒ Yes ❒ No

   Indicate total amount from those sources? Self _____________ Other Member(s) of Household ______________

4. What do you believe your annual household income will be this year? _____________

5. Use one of the charts below to determine the appropriate plan for you. Find your Household Size (the total number of individuals living in your household) and locate the column that includes your Household Income. The column heading identifies the plan for which you qualify.

Use this chart if you are applying for MHIP+

MHIP+ Plan Option Chart (see the Enrollment Guide for information on premiums and benefits)				
Household Size	**Plan 1**	**Plan 2**	**Plan 3 or 4**	**Plan 5 or 6**
1	0–$16,755	$16,756–$22,340	$22,341–$27,925	$27,926–$33,510
2	$0–$22,695	$22,696–$30,260	$30,261–$37,825	$37,826–$45,390
3	$0–$28,635	$28,636–$38,180	$38,181–$47,725	$47,726–$57,270
4	$0–$34,575	$34,576–$46,100	$46,101–$57,625	$57,626–$69,150
5	$0–$40,515	$40,516–$54,020	$54,021–$67,525	$67,526–$81,030
6	$0–$46,455	$46,456–$61,940	$61,941–$77,425	$77,426–$92,910
7	$0–$52,395	$52,396–$69,860	$69,861–$87,325	$87,326–$104,790
8	$0–$58,335	$58,356–$77,780	$77,781–$97,225	$97,226–$116,670

Use this chart if you are applying for MHIP Federal+

MHIP Federal+ Plan Option Chart (see the Enrollment Guide for information on premiums and benefits)		
Household Size	**Plan 1**	**Plan 2**
1	0–$27,925	$27,926–$33,510
2	$0–$37,825	$37,826–$45,390
3	$0–$47,725	$47,726–$57,270
4	$0–$57,625	$57,626–$69,150
5	$0–$67,525	$67,526–$81,030
6	$0–$77,425	$77,426–$92,910
7	$0–$87,325	$87,326–$104,790
8	$0–$97,225	$97,226–$116,670

6. Check the plan requested (refer to the MHIP Enrollment Guide for rates, benefits and qualifications):

MHIP+ Plans			**MHIP Federal+ Plans**		
PPO $200	❏ Plan 1	❏ Plan 2			
PPO $500	❏ Plan 3	❏ Plan 5	**HDP $1,500**	❏ Plan 1	❏ Plan 2
HMO	❏ Plan 4	❏ Plan 6			

I, the undersigned, do hereby certify that the information contained on this application is true and accurate to the best of my knowledge, information and belief. I authorize MHIP to take any and all steps necessary to verify the information provided in this application. I authorize any and all Maryland state agencies to release my most recently reported income information to MHIP for purposes of eligibility verification. The information provided will be used to verify applicant eligibility for MHIP+ or MHIP Federal+ and may not be disclosed to any individual or entity other than MHIP and Maryland state agencies. I acknowledge that I may be subject to a penalty for knowingly providing false, misleading or inaccurate information. I understand that I may be required to provide additional information. By virtue of executing and completing this application for membership in MHIP, I hereby consent to the release of tax return information to MHIP from state and/or federal tax authorities for the sole purpose of verifying income for the evaluation of MHIP Plan eligibility.

Print Applicant Name ______________________________

Signature of Applicant ______________________________ Date ____________

Print Spouse Name ______________________________
If Applicable

Spouse Signature ______________________________
If Applicable, for MHIP+ only

Signature of Parent or Legal Guardian ______________________________
If Applicant is Under Age 18 or Legally Incompetent

Final Steps

1. Attach copies of your 2011 Federal Income Tax Form or Form 4868 Filing Extension and other proof of income not included on your tax forms (Do not include schedules and other attachments).
2. Provide one of the following for proof of income if last year's household income was more than the qualifying amounts listed on page 8 and has been reduced this year or if you did not file a tax return last year:
   - Copy of your two (2) most recent pay stubs, along with a statement or note explaining how often you receive a paycheck. If a pay stub is not available, obtain a signed statement from your employer. The gross monthly income and the dates received must be shown on the statement from your employer;
   - If self-employed, provide your most recent three (3) months profit and loss statements, along with a Schedule C from last year's federal income tax return;
   - If you have income such as disability, retirement, or unemployment compensation, provide copies of award letters or bank statements showing direct deposits from these income sources.
3. Make complete copies of all your document(s) before submitting, for your own records. Do NOT submit original documents. Original documents will not be returned.
4. Mail your original MHIP+/MHIP Federal+ application, along with your original MHIP Standard application, and all necessary documents to:

MHIP
10800 Red Run Blvd, Mail Stop 380
Owings Mills, MD 21117-9685

Application Checklist

MHIP PLAN

❏ Did you sign your MHIP application?
❏ Did you include proof of Maryland residency?
❏ Did you include your carrier denial letter, physician's letter or certificate of creditable coverage?
Attach at least one of the following documents as proof of your eligibility for MHIP (see pages 3-4):

- A letter from a health insurance carrier showing denial of your application, or an exclusionary rider or statement which indicates you are paying a higher premium than MHIP's standard premium because of a medical condition; or
- A letter from your physician including the physician's license number, confirming that you have been diagnosed or treated for one of the qualifying medical conditions listed on page 4 of the Enrollment Guide; or
- Certificate(s) of creditable coverage or other documentation that proves you had 18 months of previous health care coverage, with the most recent coverage under an employer-sponsored plan, and documentation from your employer or former employer that indicates you have elected and exhausted COBRA or other continuation coverage or that you are not eligible for COBRA or other continuation coverage; or
- Proof that you are eligible for federal HCTC, by either receiving payments from the Pension Benefit Guarantee Corporation, or certification by the U.S. Department of Labor that you or your employer were affected by competition from foreign trade; or
- Proof that you were recently covered by another state high risk pool.

❏ Did you indicate whether you want to "buy down" the pre-existing medical condition waiting period (if applicable)?

MHIP FEDERAL

❏ Did you complete each item on the MHIP Federal Plan checklist?
❏ Did you sign your MHIP Federal application?
❏ Did you include proof of citizenship or lawful presence?

MHIP+/MHIP FEDERAL+

❏ Did you complete each item on the MHIP+/MHIP Federal+ checklist?
❏ Did you sign your MHIP+/MHIP Federal+ application?
❏ Did you include documentation of your income?

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