Attached is your application from TheInsuranceNet.com

Steps to complete Maryland Health Insurance Plan application.

1) Print out the attached application.

2) Complete application including all details and signatures.

3) Return application with
   requested items (i.e. copy of driver's license, etc..)

4) Mail all materials to:
   TheInsuranceNet.com
   Attn: MHIP
   5965 Sandy Ridge
   Elkridge, MD 21075

5) Call with any questions.

1-877-634-1256

TheInsuranceNet.com
"*Using technology to provide you information & people to provide you answers.*" SM

*rates subject to change without notice.

Maryland Health Insurance Plan

Subscriber Rates

Effective July 1, 2005

	Single Subscriber	Subscriber & Children	Subscriber & Spouse	Subscriber & Family
EPO Network Monthly Premium Rates				
Under 30	$235.00	$353.00	$470.00	$529.00
30 to 34	$279.00	$419.00	$558.00	$628.00
35 to 39	$323.00	$485.00	$646.00	$727.00
40 to 44	$367.00	$551.00	$734.00	$826.00
45 to 49	$411.00	$617.00	$822.00	$925.00
50 to 54	$455.00	$683.00	$910.00	$1,024.00
55 to 59	$499.00	$749.00	$998.00	$1,123.00
60 to 64	$544.00	$816.00	$1,088.00	$1,224.00
65 and Over	$588.00	$882.00	$1,176.00	$1,323.00
$500 PPO Monthly Premium Rates				
Under 30	$171.00	$257.00	$342.00	$385.00
30 to 34	$204.00	$306.00	$408.00	$459.00
35 to 39	$235.00	$353.00	$470.00	$529.00
40 to 44	$268.00	$402.00	$536.00	$603.00
45 to 49	$300.00	$450.00	$600.00	$675.00
50 to 54	$332.00	$498.00	$664.00	$747.00
55 to 59	$364.00	$546.00	$728.00	$819.00
60 to 64	$396.00	$594.00	$792.00	$891.00
65 and Over	$428.00	$642.00	$856.00	$963.00
$1,000 PPO Monthly Premium Rates				
Under 30	$141.00	$212.00	$282.00	$317.00
30 to 34	$168.00	$252.00	$336.00	$378.00
35 to 39	$194.00	$291.00	$388.00	$437.00
40 to 44	$221.00	$332.00	$442.00	$497.00
45 to 49	$247.00	$371.00	$494.00	$556.00
50 to 54	$273.00	$410.00	$546.00	$614.00
55 to 59	$300.00	$450.00	$600.00	$675.00
60 to 64	$326.00	$489.00	$652.00	$734.00
65 and Over	$353.00	$530.00	$706.00	$794.00
HDP PPO Monthly Premium Rates				
Under 30	$141.00	$212.00	$282.00	$317.00
30 to 34	$168.00	$252.00	$336.00	$378.00
35 to 39	$194.00	$291.00	$388.00	$437.00
40 to 44	$221.00	$332.00	$442.00	$497.00
45 to 49	$247.00	$371.00	$494.00	$556.00
50 to 54	$273.00	$410.00	$546.00	$614.00
55 to 59	$300.00	$450.00	$600.00	$675.00
60 to 64	$326.00	$489.00	$652.00	$734.00
65 and Over	$353.00	$530.00	$706.00	$794.00

(MHIP)

Maryland Health Insurance Plan

P.O. Box 47160
Baltimore, MD 21244-7160

(866) 780-7105

www.marylandhealthinsuranceplan.state.md.us

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04/2005

What is the Maryland Health Insurance Plan (MHIP)?

MHIP is a state high-risk pool established to provide health insurance to Maryland residents who cannot obtain individual health insurance coverage. MHIP also provides health insurance for individuals eligible for the Federal Health Coverage Tax Credit, or who have federal guaranteed-issue rights under HIPAA.

Who is eligible to participate?

You may be eligible for coverage if you are a resident of Maryland and meet any ONE of the following categories:

1. You have been denied health insurance coverage within the last (6) six months due to health reasons.
2. You currently have, or have been offered, individual health insurance that:
   - provides limited or restricted coverage for a specific medical condition.
   - excludes coverage for a specific medical condition or conditions.
   - has a premium which exceeds the MHIP premium for similar coverage due to a health condition.
3. You are a child who qualifies under eligibility category #1 or #2 above or has a medical condition listed in #8 below, and submits an application through a parent or legal guardian.
4. You have elected and exhausted health insurance benefits through COBRA, an employer-sponsored coverage or a similar state or a federal continuation plan and you have (18) eighteen months of creditable coverage with no more than a sixty-three (63) day break in coverage.
5. You have permanently moved to Maryland and are transferring from another state's high-risk pool and have no more than a sixty-three (63) day break in coverage.
6. You are age 55 to 64 and eligible for a Federal Health Coverage Tax Credit through your receipt of a pension through the Pension Benefit Guaranty Corporation.
7. Your job has been affected by competition from foreign trade and you are currently receiving a Trade Readjustment Allowance or Unemployment Insurance and are eligible for the Federal Health Coverage Tax Credit.
8. You have one of the medical conditions on the following list.

Behavioral Health (Psychiatric)
- Bipolar Disorder
- Chemical Dependency
- Dementia
- Psychotic Disorders

Blood/Blood Forming
- Aplastic Anemia
- Hemocromatosis
- Hemophilia
- Sickle Cell Disease

Cardiovascular
- Angina Pectoris
- Cardiomyopathy
- Congestive Heart Failure
- Coronary Artery Disease
- Coronary Insufficiency
- Coronary Occlusion

Endocrine (Hormonal)
- Addison's Disease
- Cystic Fibrosis
- Diabetes (Type I and II)
- Porphyria
- Wilson's Disease

Gastrointestinal
- Ascites
- Banti's Disease or Syndrome
- Cirrhosis of the Liver
- Crohn's Disease
- Esophageal Varicies
- Hepatitis B & C
- Ulcerative Colitis

Infectious
- AIDS
- HIV Positivity

Musculoskeletal/ Connective
- Ankylosing Spondylitis
- Lupus Erythematosus Disseminate
- Rheumatoid Arthritis
- Scleroderma

Pulmonary (Lung)
- Chronic Obstructive Pulmonary Disease
- Emphysema

Neoplasm (Cancers)
- Cancer (except skin cancer) treated or diagnosed within the past 5 years
- Hodgkin's Disease
- Leukemia
- Multiple Myeloma
- Non-Hodgkin's Lymphoma
- Wilm's Tumor

Neurologic
- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- Friederich's Ataxia
- Guillain Barre Syndrome
- Huntington's Disease
- Hydrocephalus
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Myotonia
- Palsy
- Paraplegia
- Parkinson's Disease
- Quadraplegia
- Stroke
- Tay-Sachs Disease

Other
- Kidney Disease requiring Dialysis
- Major Organ Transplant
- Pregnancy

What type of coverage is included?

Your coverage under MHIP includes the following benefits:

- Medical care and equipment
- Behavioral health services
- Prescription drugs

What Plan Benefit Options are available?

There are four Plan Benefit Options available in MHIP:

1. **EPO:** Under the Exclusive Provider Organization (EPO) plan, MHIP has an established network of providers. Most services will be paid in full, excluding applicable copayments, if you utilize network providers (see Health Benefit Summary for details). Services for non-network providers will not be paid, with the exception of emergency or urgent care. In an EPO, you are required to choose a doctor as your primary care physician (PCP), who will act as a "gatekeeper" for medical services. A referral must be obtained from your PCP in order to seek other services. This plan has a $250 prescription drug deductible.
2. **PPO:** Under MHIP's three Preferred Provider Organization (PPO) plan options, members receive coverage after satisfying an annual deductible and the applicable coinsurance and copayment amounts. Refer to the Health Benefit Summary to determine your level of responsibility. There is an established network of providers, which allows maximum benefit coverage when those providers are used. Benefits will be reduced when using providers outside the network. If you use the services of a non-participating provider, you may be required to pay the difference between what the provider charges and what MHIP allows as payment.

NOTE: MHIP members who select the High Deductible Health Plan (HDP) PPO can separately establish a Health Savings Account to pay for certain medical expenses not covered by the HDP. Health Savings Accounts (HSAs) receive favorable tax treatment by the federal government. Applicants interested in an HSA should establish the account through a custodial or trust separate from MHIP and may wish to consult their insurance, financial or tax advisor. Information is available at the IRS website: www.irs.gov.

PPO Plan	Individual Medical Deductible	Family Medical Deductible	Prescription Deductible
$500 PPO	$500	$1,000	$100
$1,000 PPO	$1,000	$2,000	$250
High Deductible Health Plan (HDP)	$1,200	$2,400	Pharmacy deductible is combined with Medical deductible

May I apply for MHIP if I have existing insurance coverage?

You are not eligible for MHIP if you are enrolled in or eligible for Medicare, Medicaid, the Maryland Children's Health Program (MCHP) or comparable employer-sponsored group health insurance; otherwise, your eligibility may depend on what coverage you currently have and under what criteria you are applying.

- If you have an existing individual insurance policy, you may apply to MHIP if you otherwise meet the program's eligibility requirements. If you have employer-sponsored group health insurance including COBRA, MHIP will consider your application if your group benefits are not comparable to MHIP's. Applicants covered by, or with access to employer-sponsored group health coverage, must include a copy of their employer's summary of health benefits with their MHIP Enrollment Application Form.
- If you are applying as an HCTC-eligible individual, you may have an existing individual, group or COBRA policy; however you will be ineligible for coverage if you have access to TRICARE/CHAMPUS through the U.S. military health system or employer-sponsored coverage under which the employer pays for at least half of the cost.

Once accepted into MHIP, you must cancel your other health insurance coverage.

May I be covered under both MHIP and another insurance plan?

No. You may not have coverage under Medicare (either Part A or Part B), Medicaid, Maryland Children's Health Program (MCHP), Federal Employee Health Benefits Program (FEHBP), an employer-sponsored group plan, or an individual health insurance policy. However, if you are in your initial waiting period for group coverage with a new employer and you meet any of the other eligibility criteria, you are eligible for MHIP coverage until that waiting period ends. In certain circumstances, the time period between your application receipt date and your effective date of MHIP coverage constitutes a "waiting" period.

Do I have to be a resident of the State of Maryland to apply?

Yes. You must be a resident of Maryland. If you are applying under eligibility categories A or D (Medical Eligibility or Health Condition Eligibility) on the Enrollment Application Form, you must show proof that you have been a Maryland resident for at least six (6) months prior to your effective date of coverage with MHIP. If you are applying for any other eligibility category, you only need to show Maryland residency as of your application date.

Proof of residency may be in the form of a current Maryland driver's license or state identification card issued no less than six (6) months prior to your effective date of coverage with MHIP. Alternate proof of residency may include rental agreements, property tax bills, pay stubs, utility bills, voter registration card or a Maryland state income tax return.

When will my coverage be effective?

Once accepted, your effective date of coverage will be as follows:

- If your MHIP Enrollment Application Form is received on or before the fifteenth of the current month, coverage will begin on the first day of the next month.
- If your MHIP Enrollment Application Form is received after the fifteenth of the current month, coverage will begin on the first day after the following month. (Example: if your MHIP Enrollment Application Form is received on August 16th, coverage would be effective on October 1st.)

How do I complete the Enrollment Application Form?

Tear out the Enrollment Application Form included at the end of this booklet. In order for your application to be complete, please answer all applicable questions and include ALL required documentation. If two or more items are incomplete, your application may be denied.

Complete the Enrollment Application Form as follows:

1. Select the Plan Benefit Option you want.
2. Complete the Applicant Information. Indicate BOTH a physical and mailing address if you want Plan correspondence and materials (i.e. ID cards, premium coupons and Explanation of Benefits) mailed to an address OTHER THAN your physical address. Also, if someone other than you will be paying your MHIP premium, indicate the name and phone number in the space provided.
3. Select the Coverage Type you want.
4. Complete Spouse/Dependent Information, if applicable.
5. Indicate your Employment Status and specify whether there is an employer health plan available.
6. Complete the applicable Eligibility Category and attach the required documents outlined below.

A. Medical Eligibility

You may be eligible for coverage if you meet ONE of the following criteria:

- You have been denied health insurance coverage within the last six (6) months due to health reasons. If this applies to you, attach a copy of the insurance company denial letter. The letter must be dated no more than six (6) months prior to your effective date of MHIP 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(s). If this applies to you, attach a copy of your acceptance letter or statement of coverage, as well the policy rider or letter that excludes the specific medical condition(s).
- You currently have, or have been offered, individual health insurance coverage, but the premium rate exceeds the MHIP premium rate for similar coverage DUE TO A HEALTH CONDITION. If this applies to you, attach a premium statement from your current policy, dated within the last sixty (60) days, or a written quote from a carrier dated within the last sixty (60) days. Either must show a higher rate than MHIP due to a health condition.

B. Loss of Group Coverage (HIPAA) Eligibility

ALL of the following criteria must apply to qualify under this eligibility category:

- If available, you have elected and exhausted health insurance benefits through COBRA or a similar state or federal continuation plan. (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 eighteen (18) months of creditable coverage with the most recent coverage under an employer-sponsored plan, governmental plan, church plan or a health plan offered in conjunction with any of these plans. Certificates of Creditable Coverage must show a total of eighteen (18) months of creditable coverage.
- You have no more than a sixty-three (63) day break in coverage. This period is measured from the date your coverage stopped to the effective date of your MHIP policy. However, the waiting period between your application receipt date and your effective date of coverage will not be counted.
- 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.

Attach ALL Certificates of Creditable Coverage showing eighteen (18) months of creditable coverage. If you cannot get a Certificate of Coverage, you can prove that you have creditable coverage by providing any of the following:

- Summary plan description forms from your previous health plan
- Correspondence from your previous health plan
- Pay stubs showing deductions for health insurance
- Health insurance identification card that shows effective and termination dates
- Medical records showing health coverage
- Third party statements verifying the coverage

C. Transfer From Another High-Risk Pool Eligibility

You may be eligible for coverage if BOTH of the following apply:

- You have permanently moved to Maryland and are transferring from another state's high-risk pool; AND
- You have no more than a sixty-three (63) day break in coverage. This period is measured from the date your coverage stopped to the effective date of your MHIP policy. However, the waiting period between your application receipt date and your effective date of coverage will not be counted.

Attach a Certificate of Creditable Coverage and a copy of your plan identification card. If you cannot get a Certificate of Coverage, you may provide other documentation from the high-risk pool that shows creditable coverage, including:

- Summary plan description forms from the high-risk pool
- Correspondence from the high-risk pool
- Health insurance identification card that shows effective and termination dates
- Medical records showing health coverage
- Third party statements verifying the coverage

D. Health Condition Eligibility

You may be eligible for coverage if you have any of the health conditions listed on page 2 of this booklet.

Attach a letter written by your physician on the physician's stationery confirming that you have been diagnosed or treated for one of the conditions on that list, with the appropriate dates of service for the diagnosis or treatment. The letter must contain:

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

E. Trade Adjustment Assistance Act Eligibility — Health Coverage Tax Credit (HCTC)

You may be eligible for coverage if you meet ONE of the following criteria:

- You are a retiree aged 55 to 64 receiving pension payments from the Pension Benefit Guaranty Corporation; or
- 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.

If you qualify for MHIP under this eligibility category, MHIP is assuming you are eligible for a Federal Health Coverage Tax Credit (HCTC), which pays 65% of the cost of your monthly MHIP premium. However, the federal government will make the final determination about eligibility for the health coverage tax credit. In order for your spouse and/or children to receive this credit, they must:

- Not be imprisoned
- Not be enrolled in Medicare, Medicaid, the Maryland Children's Health Program (MCHP), or the Federal Employees Health Benefits Program (FEHBP)
- Not be covered under an employer's health plan paying 50 percent or more of their health insurance premiums

7. Indicate whether you or any dependents, who will be covered by your policy, have insurance through employer or individual coverage, Medicare, COBRA, Medicaid, or Maryland Children's Health Program (MCHP).
8. If you are applying for EPO coverage, select a Primary Care Physician (PCP) for each individual to be covered. Refer to the enclosed Primary Care Provider listing.
9. Indicate the total annual household income including wages, Social Security, investment income, alimony, etc.
10. Indicate how you heard about the Maryland Health Insurance Plan.
11. Sign and date the Enrollment Application Form (include spouse or authorized representative signature, if applicable) to affirm that you have read and agreed to its terms.

What are my final steps?

1. Attach proof of Maryland residency. All applicants must be a Maryland resident. The length of residency needed to qualify for coverage differs depending on the eligibility category under which you are applying.
   - If you are applying under eligibility categories A or D (Medical Eligibility or Health Condition Eligibility), you must show proof that you have been a Maryland resident for at least six (6) months prior to your effective date of coverage with MHIP.
   - If you are applying under eligibility categories B, C or E (Loss of Group Coverage – HIPAA; Transfer from Another High-Risk Pool; or Trade Adjustment Assistance Act Eligibility), you only need to show Maryland residency as of your application date.

Provide a copy of the front of your current Maryland driver's license or State identification card. If you need to show six (6) months of residency, and your current Maryland driver's license or State identification card has been issued or renewed less than six (6) months prior to the effective date of your MHIP coverage, submit any of the following dated more than six (6) months before the effective date of your MHIP coverage: copy of rental agreements, property tax bills, pay stubs, utility bills, voter registration card or a Maryland state income tax return.

2. Attach copy of a birth certificate or adoption papers if you are applying for coverage of a dependent child.
3. Detach your signed Enrollment Application form from this booklet and mail the signed form along with the required documentation in the enclosed envelope to:

Maryland Health Insurance Plan
ATTN: Enrollment Department
P.O. Box 47160
Baltimore, MD 21244-7160

Send no payment at this time. You will be billed upon approval of your application.

Failing to submit a completed Enrollment Application Form and the required documentation will result in a delay in activating your coverage.

If you need help filling out the Enrollment Application Form, you may contact an Insurance Producer (broker or agent) in your area or call the MHIP Member Solution Center at (866) 780-7105. If an Insurance Producer helps you complete the Enrollment Application Form, the Producer should fill out the bottom portion of page 4 of the form.

Maryland Health Insurance Plan
P.O. Box 47160, Baltimore, MD 21244 (866) 780-7105

04/2005

Enrollment Application Form

www.marylandhealthinsuranceplan.state.md.us

PLEASE PRINT

1. Check Plan Benefit Option for which you are applying.

❑ EPO ❑ $500 Deductible PPO ❑ $1,000 Deductible PPO ❑ $1,200 High Deductible Health Plan (HDP)

2. Complete Applicant Information (Must complete entire section).

Last Name: ____________________ First Name: ________________ MI: ______

Physical Address: ____

Physical Address: ____

City: ____________________ State: ____________________

Zip Code: ________________ County: ____________________

Home Phone: ( ) ____________ E-Mail: (If available) ________________

Name of Authorized Representative or Third-Party Payor: ________________ Phone: ( ) ________

Mailing Address: ____

Mailing Address: ____

City: ____________________ State: ____________________

Zip Code: ________________ County: ____________________

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Separated ❑ Widowed

Social Security Number:

__ __ __ / __ __ / __ __ __ __

Sex: ❑ Male ❑ Female

Date of Birth:

__ __ / __ __ / __ __ __ __

Age: ________________

If married, is spouse employed?

❑ Yes ❑ No

3. Indicate Coverage Type for which you are applying.

❑ Subscriber Only ❑ Subscriber and Spouse ❑ Subscriber and Child(ren) ❑ Subscriber and Family

4. Complete Spouse/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
____________	________	___	_ _ / _ _ / _ _ _ _	_ _ _ / _ _ / _ _ _ _	❑ ❑	❑ ❑	❑ ❑
____________	________	___	_ _ / _ _ / _ _ _ _	_ _ _ / _ _ / _ _ _ _	❑ ❑	❑ ❑	❑ ❑
____________	________	___	_ _ / _ _ / _ _ _ _	_ _ _ / _ _ / _ _ _ _	❑ ❑	❑ ❑	❑ ❑
____________	________	___	_ _ / _ _ / _ _ _ _	_ _ _ / _ _ / _ _ _ _	❑ ❑	❑ ❑	❑ ❑

5. Indicate Employment Status.

❑ Employee ❑ Self-Employed ❑ Not Employed ❑ Retired ❑ Disabled

Name of Employer: ____

Employer Address: ____

City: ________________ State: ____________ Zip Code: ____________

Employer Health Plan Available? ❑ Yes ❑ No

Work Phone Number:

( ) ____________

Occupation:

____

If yes, why are you not covered? ____

Spouse Health Plan Available? ❑ Yes ❑ No

If yes, why are you not covered? ____

6. Complete one of the 5 sections below (A, B, C, D, or E) that represent your Eligibility Category (Check ALL BOXES that apply).

See pages 4-6, Eligibility Categories A-E of the application booklet 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, restricted coverage, exclusionary rider or statement denoting higher premium than MHIP's due to a medical condition dated within the last 6 months.

❑ I have been denied individual health insurance in the last 6 months.

❑ I have or have been offered limited or restricted individual health coverage.

❑ I have or have been offered individual health insurance that excludes specific medical conditions.

❑ I have or have been offered individual health insurance coverage with a premium rate that exceeds the MHIP premium for similar coverage for a health condition.

B. Loss of Group Coverage [HIPAA] (All statements below MUST apply and be checked). 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 5 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.

C. Transfer from Another High Risk pool. (Answer yes/no). In addition to your proof of Maryland residency, you MUST include a Certificate of Creditable coverage from your carrier or refer to page 5 for a list of alternate documents.

1. I have permanently moved to Maryland. ❑ Yes ❑ No
2. I have transferred from another State High Risk pool with no more than a 63-day break in coverage. ❑ Yes ❑ No

D. 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 60 listed medical conditions.

Please write below the medical condition **from the list on page 2 of the application booklet** which applies to you.
The condition you indicate MUST appear on the list AND must match exactly the physician's letter validating the condition.

____

____

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 Medicare Part A or B, Medicaid, or Maryland Children's Health Program (MCHP)? ❑ **Yes** ❑ **No**

Are you enrolled in or eligible for any other individual or employer health plans, including COBRA? ❑ **Yes** ❑ **No**
(If yes, please specify below)

Plan: ____Policy #: ____

City:______________________________State: _________________From Date: _______________ To Date: ________________

Complete this section if your spouse or dependent(s) have other health insurance, including employer, individual, federal or state plans.

Policy Holder Name	Spouse	Dependent(s)	Insurance Plan	Policy Number	City	State	From Date	To Date
___________________	❑	❑	_____________________	_______________	________	____	_________	_________
___________________	❑	❑	_____________________	_______________	________	____	_________	_________
___________________	❑	❑	_____________________	_______________	________	____	_________	_________
___________________	❑	❑	_____________________	_______________	________	____	_________	_________

8. EPO 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) Refer to Provider Listing	Existing Patient of this PCP?
Applicant:	_____________________	_________________________	___	_________________________	❑ Yes ❑ No
Spouse:	_____________________	_________________________	___	_________________________	❑ Yes ❑ No
Child:	_____________________	_________________________	___	_________________________	❑ Yes ❑ No
Child:	_____________________	_________________________	___	_________________________	❑ Yes ❑ No
Child:	_____________________	_________________________	___	_________________________	❑ Yes ❑ No

9. 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

10. 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

11. 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 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 to it 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, 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, 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.

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: __________

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.

Insurance Producer Name: ____________________ Tax ID#: __________

License #: ____________________ Expiration Date: __________

Phone Number: ____________________

Signature: ____________________ Date: __________

Company Name: ____________________ Address: ____________________

City: ____________________ State: __________ Zip: __________