BEFORE YOU START:

What to Expect from Your Pre-Existing Condition Insurance Plan Application

The Pre-Existing Condition Insurance Plan provides a new health coverage option to people who meet these requirements:

- Have been without health coverage for at least six months
- Have a pre-existing condition or have been denied health coverage because of their health condition
- Are U.S. citizens or are residing in the U.S. legally

You pay a monthly premium and an annual deductible for Pre-Existing Condition Insurance Plan (PCIP) coverage. Benefits include primary and specialty care, hospital care, and prescription drugs. You have three plan options to meet your health care needs: the Standard Option, the Extended Option, and the Health Savings Account Option.

After you complete this application, you'll mail it to the address on page [9]. We'll mail you a letter in about 2-3 weeks letting you know whether your application is approved or if we need more information.

If you're approved, your coverage effective date will be based on the date we got your complete application. **If we get your application and documentation on or before the 15th of the month, your coverage will be effective the first day of the next month.** If we get your application after the 15th, your coverage will be effective the first day of the second month, unless you choose to have your coverage start on the first day of the next month. If we approve your application, we will let you know how to choose an earlier effective date. Coverage always begins on the first day of the month.

Example:

We get your complete application and supporting documents on . . .	**Your coverage starts . . .**
March 1-15	April 1
March 16-31	May 1 **or** April 1 (if you ask for coverage to start sooner)

For more information, visit www.pcip.gov or call 1-866-717-5826 (TTY 1-866-561-1604).

2012 Pre-Existing Condition Insurance Plan Application

Please complete this application in full in blue or black ink. You must answer every question.

Section 1. Information about the Person Applying for Coverage

Last Name	**First Name**	**Middle Initial**	**Maiden Name** (if applicable)	**Age**	**Date of Birth** (MM/DD/YYYY)
Social Security Number (if you have one)	**Gender** ☐ Male ☐ Female	**Phone Number with Area Code**		**Email Address** (if you have one)	
Permanent Address					
City			**State**		**ZIP Code**
Mailing Address (only if different from your Permanent Address)					
City			**State**		**ZIP Code**

Section 2. Information about the State Where You Live

To be eligible for this coverage, you must live in a state that is served by the Federally-run Pre-Existing Condition Insurance Plan. What state do you live in? _____

Section 3. Information about Your Citizenship or Immigration Status

Check one of the following boxes:

☐ **I am a citizen of the United States.** You must provide your Social Security Number in Section 1, because you're attesting that you are a U.S. citizen. We'll match your information, including your Social Security Number, with information in Federal records.

☐ **I am a noncitizen national of the United States.** You must provide a copy of a document that confirms your status as a noncitizen national, such as a copy of a U.S. passport that shows your national status.

☐ **I am a noncitizen who is lawfully present in the United States.** You must provide a copy of your immigration document, including a document that has your Alien Registration Number or I-94 Number, to verify your current immigration status. A list of acceptable documents is on page [9] of this form.

Section 4. Information about Your Medical Condition or Diagnosis

Check the box that applies to you:

☐ **I have a medical condition, disability, or illness, or I had a medical condition, disability, or illness in the past**.

NOTE: You must provide a copy of a letter from a doctor, physician assistant, or nurse practitioner dated within the past 12 months stating that you have or had a medical condition, disability, or illness. This letter must include your name and medical condition, disability, or illness and the name, license number, state of licensure, and signature of the doctor, physician assistant, or nurse practitioner.

☐ **I've been denied health coverage.** Because I have a medical condition, I received either a denial letter from an insurance company for individual insurance coverage (not health insurance offered through a job) in my state that is dated within the past 12 months, **or** I received a letter dated within the past 12 months from an insurance agent or broker licensed in my state that tells me I'm not eligible for individual insurance coverage from one or more insurance companies because of my medical condition.

NOTE: You must provide a copy of the insurance company's denial letter or a copy of the agent or broker's letter.

☐ **I've been offered individual health coverage with an exclusionary rider.** I received an offer of individual insurance coverage (not health insurance offered through a job) that I **didn't** accept from an insurance company in my state that is dated within the past 12 months. This offer of coverage has a rider that says my specific medical condition won't be covered if I accept the offer.

NOTE: You must provide a copy of your offer of coverage with the rider that shows that your specific medical condition won't be covered. Note that if you currently have insurance coverage that doesn't cover your specific medical condition, you aren't eligible for the Pre-Existing Condition Insurance Plan.

☐ **I'm under age 19, or I live in Massachusetts or Vermont, and I've been offered individual health coverage for a high premium as described below.** I have a medical condition, and I received an offer of individual insurance coverage (not health insurance offered through a job) that I **didn't** accept from an insurance company in my state that is dated within the past 12 months. This offer of coverage shows a premium that's at least twice as much as the Pre-Existing Condition Insurance Plan premium (the monthly payment you make to an insurer to get and keep insurance) for the Standard Option in my state.

NOTE: You must provide a copy of the insurance company's letter showing the premium for the individual coverage you were offered, but did not accept. To find out if the premium you were offered is twice as much as the premium in the Pre-Existing

Condition Insurance Plan for the Standard Option in your state, visit www.pcip.gov or call 1-866-717-5826 (TTY 1-866-561-1604).

Section 5. Information about Your Other Coverage

To be eligible for the Pre-Existing Condition Insurance Plan, you must have been without other health coverage for at least 6 months from the date of this application. **Have you had any of the following types of coverage at any point in the past 6 months? You must answer each question.**

1. Individual or job-based health plan, including COBRA?
   ☐ Yes ☐ No
2. Medicare (Part A and/or Part B)?
   ☐ Yes ☐ No
3. Medicaid?
   ☐ Yes ☐ No
4. Children's Health Insurance Program (or CHIP)?
   ☐ Yes ☐ No
5. A state high risk pool?
   ☐ Yes ☐ No
6. TRICARE (military health insurance)?
   ☐ Yes ☐ No
7. Health coverage provided by a public health plan established by a state, the U.S. government such as coverage provided to veterans enrolled in VA health care, or a foreign country?
   ☐ Yes ☐ No
8. FEHBP (health insurance for Federal employees or retirees), including Temporary Continuation of Coverage (TCC)?
   ☐ Yes ☐ No
9. Health benefit plan provided to Peace Corps workers?
   ☐ Yes ☐ No
10. Services provided by the Indian Health Service or by a Tribe or Tribal organization for treating your medical condition?
    ☐ Yes ☐ No

We also want to know about any health coverage you had in the past year. If you had health coverage from more than two insurance companies or providers in the past year, you only need to identify the two most recent ones. If you didn't have coverage, you can leave this section blank.

Name of Insurance Company or Program that Provided Your Health Coverage:		
Insurance Company Address:		
City:	**State:**	**ZIP Code:**
Insurance Company Phone Number with Area Code:		
Employer Name (if coverage was provided by the employer):		
Coverage Start Date: (MM/DD/YYYY)	**Coverage End Date:** (MM/DD/YYYY)	
Reason Your Health Coverage Ended (check all that apply): ☐ Because you or someone in your family lost or left their job. ☐ Because your insurance company stopped covering dependents. ☐ Because you or someone in your family stopped working full-time and were no longer eligible for benefits. ☐ Because you moved out of the insurance company's service area. ☐ Other (state the reason your coverage ended):		

Information for any other health coverage in the past 12 months:

Name of Insurance Company or Program that Provided Your Health Coverage:		
Insurance Company Address:		
City:	**State:**	**ZIP Code:**
Insurance Company Phone Number with Area Code:		
Employer Name (if coverage was provided by the employer):		
Coverage Start Date: (MM/DD/YYYY)	**Coverage End Date:** (MM/DD/YYYY)	
Reason Your Health Coverage Ended (Check All That Apply): ☐ Because you or someone in your family lost or left their job. ☐ Because your insurance company stopped covering dependents. ☐ Because you or someone in your family stopped working full-time and were no longer eligible for benefits. ☐ Because you moved out of the insurance company's service area. ☐ Other (state the reason your coverage ended):		

Section 6. Choose Your 2012 Plan Option

Check the box of the plan option you choose. Get more information about these options — including premiums, benefits, and cost-sharing — at www.pciplan.com.

☐ **2012 Standard Option** (Higher Deductible, Lower Premiums)
- $2,000 in-network/$3,000 out-of-network deductible for medical care
- $500 formulary/$750 non-formulary deductible for prescription drugs

☐ **2012 Extended Option** (Lowest Deductible, Higher Premiums)
- $1,000 in-network/$1,500 out-of-network deductible for medical care
- $250 formulary/$375 non-formulary deductible for prescription drugs

☐ **2012 Health Savings Account Option** (Highest Deductible, Lower Premiums)
- $2,500 in-network/$3,000 out-of-network deductible combined for both medical care and prescription drugs

Section 7. Verify Your Understanding of this Application and Sign It

1) I understand that my coverage won't start until (a) this completed application and all required documents are received and approved, and (b) I'm billed for the first month's premium and my payment is received and processed.

2) I understand that it's my responsibility to inform the Pre-Existing Condition Insurance Plan of any changes that may affect my eligibility, including any health insurance coverage I may get in the future.

3) I understand that, if I move out of the area served by the Pre-Existing Condition Insurance Plan, I must notify the Plan so I can disenroll.

4) I understand that if I voluntarily disenroll from the Pre-Existing Condition Insurance Plan or if I'm disenrolled involuntarily (for example, because I didn't pay my premium on time), I can't re-apply for enrollment until at least 6 months after my coverage ends.

5) I understand and agree to the release of the information on this application to the U.S. Department of Agriculture's National Finance Center, other Federal agencies, and Federal contractors to determine my eligibility and enroll me in the Pre-Existing Condition Insurance Plan.

6) I understand that, by signing below, I certify that all information and documents provided as part of this application are complete, accurate, and true to the best of my knowledge. I understand that, if this application has intentional material misstatements or omissions, the Pre-Existing Condition Insurance Plan may, during the first 2 years of my enrollment, (a) cancel my enrollment as though it were never effective and refund my premiums, less any claims that were paid on my behalf, and/or (b) take any other action available by law.

Please sign and date below:

Signature		**Today's Date (MM/DD/YYYY)**
If you are a parent or legal guardian or an authorized representative of the person applying for coverage, you must sign above and provide the information below:		
Full Name		**Phone Number with Area Code**
Mailing Address		
City	**State**	**ZIP Code**
Your Relationship to the Person Applying for Coverage: ☐ Parent ☐ Legal Guardian ☐ Legally Authorized Representative		

Section 8. How You Heard about the Pre-Existing Condition Insurance Plan

OPTIONAL: Tell us how you heard about the Pre-Existing Condition Insurance Plan (check all that apply).

- ☐ Family Member or Friend
- ☐ Coworker or Colleague
- ☐ Mail Solicitation
- ☐ Internet Search
- ☐ Other
- ☐ Internet Article
- ☐ Radio
- ☐ Television
- ☐ Publication (newspaper, magazine or journal)
- ☐ Healthcare Provider
- ☐ Insurance Company
- ☐ Insurance Broker
- ☐ Public Event

Section 9. Application Checklist

☐ I've completed this entire application and answered every question.

☐ I've signed and dated this application.

☐ I've included a copy of one of these documents:

- An insurance company's denial letter
- An insurance agent or broker's letter
- An insurance company's letter offering coverage with a rider
- A letter from a doctor, physician assistant, or nurse practitioner
- A letter from an insurance company showing the premium quote I was offered for coverage.

☐ **U.S. Citizens Only:** I've provided my Social Security Number.

☐ **U.S. Noncitizen Nationals Only:** I've included a copy of a document that confirms my status as a noncitizen national, such as a copy of a U.S. passport that shows my national status.

☐ **Noncitizens Only:** I've included a copy of my immigration documents, including at least one with my Alien Registration Number or I-94 Number that will be used to verify my status. I've provided a copy of one of these documents:

- ☐ I-327 (Reentry Permit)
- ☐ I-551 (Permanent Resident Card)
- ☐ I-571 (Refugee Travel Document)
- ☐ I-766 (Employment Authorization Document)
- ☐ Machine Readable Immigrant Visa (with Temporary I-551 Language) affixed to Unexpired Foreign Passport
- ☐ Temporary I-551 Stamp (on passport or I-94) affixed to I-94 or Unexpired Foreign Passport
- ☐ I-94 (Arrival/Departure Record) with Unexpired Foreign Passport
- ☐ Unexpired Foreign Passport for Visa Waiver Program travelers
- ☐ I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status) accompanied by I-94 and an Unexpired Foreign Passport
- ☐ DS-2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status) accompanied by I-94 and an Unexpired Foreign Passport
- ☐ Other Document with an I-94 or Alien Number

Mail in Your Completed Application

The Official Processing Center for the Pre-Existing Condition Insurance Plan is in New Orleans, Louisiana. Mail your application and all required documents to:

National Finance Center
Pre-Existing Condition Insurance Plan
P.O. Box 60017
New Orleans, LA 70160-0017

Don't send any payment with this application. If you're eligible, we'll mail you a letter that includes the amount of your monthly premium and instructions for making your first premium payment to complete your enrollment. If you have questions or need help completing this application, call **1-866-717-5826** (TTY 1-866-561-1604), or visit **www.pcip.gov**.

Privacy Act and Paperwork Reduction Notice

Section 1101 of the Patient Protection and Affordable Care Act, Public Law 111-148, authorizes us to collect the information on this form. The information you provide will allow the United States Department of Health and Human Services through the United States Department of Agriculture's National Finance Center to determine if you're eligible for the Pre-Existing Condition Insurance Plan. We are required to ask for your Social Security Number if you attest that you're a U.S. citizen. We match your information, including your Social Security Number, against Federal records, such as those maintained by the Social Security Administration. We perform this match by computer to confirm your information and verify whether you are eligible for the Pre-Existing Condition Insurance Plan. Only individuals who are citizens or nationals of the United States or are otherwise lawfully present in the United States are eligible for this program. If you don't provide this information, we won't be able to make a decision on your application.

Paperwork Reduction Act Statement. This information collection meets the requirements of 44 United States Code §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. The valid OMB control number for this information collection is 0938-1095. We estimate that it will take about 1 hour to read the instructions, gather the facts, and answer the questions.

You may send comments on our time estimate to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **Send only comments relating to our time estimate to this address, not your application form**.