

OKLAHOMA TEMPORARY HIGH RISK POOL APPLICATION



HOW TO APPLY

Complete the enclosed Oklahoma Temporary High Risk Pool (OTHRP) Application for Coverage and submit it with the first month's premium.

ELIGIBILITY DOCUMENTATION

You must provide one of the following to document U.S. citizenship or that you are lawfully present in the United States:

- A copy of your U.S. passport, a copy of your birth certificate, a copy of your certificate of citizenship, or a copy of your naturalization certificate (If you are a U.S. Citizen)

-or-

- A copy of a U.S. passport that confirms your national status (if you are a noncitizen national of the United States)

-or-

- A copy of your immigration document, including a document that has your Alien Registration Number or I-94 Number, for verification of your current immigration status (if you are a noncitizen that is lawfully present in the United States)

-and-

You must provide one of the following to document residency in Oklahoma:

- A copy of your recent Oklahoma tax return

-or-

- A copy of your Oklahoma driver's license showing current Oklahoma address

-or-

- A copy of your utility bill showing current Oklahoma address

-and-

You must provide one of the following:

- A signed physician's statement (See Pre-Existing Medical Conditions Requirement on page 6)

-or-

- A copy of a denial letter for your medical condition, or a rider you did not accept that excludes coverage for your medical condition, from an insurance company doing business in Oklahoma

-or-

- A copy of an insurance company's offer to issue coverage with a rating that is 125 percent, or more, higher than the company's standard rate for a child under the age of 19 due to the child's pre-existing medical condition

NOTE: PLEASE SUBMIT YOUR FIRST MONTH'S PREMIUM PAYMENT WITH YOUR APPLICATION. CHECKS SHOULD BE MADE PAYABLE TO "OTHRP."

Notification of Acceptance or Denial of Coverage: If your OTHR Application for Coverage meets all program requirements, the OTHR Administrator will notify you of your acceptance. A policy, schedule of benefits and identification card will be issued to you.

If your application is processed and you meet all of the eligibility requirements, but the pool has met the enrollment capacity, you will be placed on a waiting list and will be contacted when coverage is available.

Effective Dates and Premium Payments: With certain exceptions, eligible applicants who are accepted for OTHR membership will have coverage effective on the first day of the month following the date their application is accepted.

MAIL THE APPLICATION TO: Blue Cross and Blue Shield of Oklahoma
OTHR Administrator
P.O. Box 6129
Abilene, TX 79608-6129

FOR MORE INFORMATION: CALL 1-877-885-3717
or VISIT bcbsok.com/ohrp

OKLAHOMA TEMPORARY HIGH RISK POOL APPLICATION



PLEASE PRINT ALL INFORMATION

SECTION A – APPLICANT INFORMATION

LAST NAME		FIRST NAME		MIDDLE NAME		SEX M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH
ADDRESS: NUMBER, STREET			CITY	STATE	ZIP	COUNTY	
TELEPHONE NUMBER ()						SOCIAL SECURITY NUMBER	
E-MAIL ADDRESS							
EMERGENCY CONTACT: LAST NAME		FIRST NAME		MIDDLE NAME		RELATIONSHIP TO APPLICANT	
EMERGENCY CONTACT ADDRESS: NUMBER, STREET			CITY	STATE	ZIP	TELEPHONE NUMBER	
EMPLOYER NAME AND ADDRESS (IF APPLICABLE)						EMPLOYER'S TELEPHONE NUMBER	
ARE YOU NOW TOTALLY DISABLED? <i>If "yes", please describe your disability.</i> YES <input type="checkbox"/> NO <input type="checkbox"/>							

SECTION B – INFORMATION ABOUT THE YOUR CITIZENSHIP OR IMMIGRATION STATUS

Please check one of the following boxes:

- I am a citizen of the United States.** You must provide a copy of a document that confirms your citizenship, such as a copy of your U.S. passport, a copy of your birth certificate, a copy of your certificate of citizenship, or a copy of your naturalization certificate.
- 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, for verification of your current immigration status.

SECTION C – HEALTH CARE COVERAGE INFORMATION

To be eligible for this coverage, you must have been without other health coverage for at least six (6) months from the date of this application. Please indicate below any coverage you may have had at any point in the last 6 months, **you must answer yes or no to each.**

1. Health insurance coverage, including individual health insurance coverage or short-term limited-duration insurance? Yes No
2. Limited benefit plans, also known as "mini-medical" plans? Note: "mini-medical" plans or "mini-med" plans are insurance policies that provide very limited coverage for your doctor, hospital, and drug bills, and have high deductibles and low annual dollar limits on benefits. Yes No
3. Job-based health insurance, including COBRA? Yes No
4. Medicare (Part A and/or Part B)? Yes No
5. Medicaid? Yes No
6. Children's Health Insurance Program (or CHIP)? Yes No
7. A state high risk pool? Yes No
8. TRICARE (military health insurance)? Yes No
9. Health coverage provided by a public health plan established or maintained by a state, the U.S. government, or a foreign country, such as coverage provided to veterans enrolled in VA health care, or coverage provided by a foreign country? Yes No
10. FEHBP (health insurance for Federal employees or retirees), including Temporary Continuation of Coverage (TCC)? Yes No
11. Health benefit plan provided to Peace Corps workers? Yes No
12. Services provided by the Indian Health Service or by a Tribe or Tribal organization for treating your medical condition? Yes No
13. Does your employer or your family member's employer offer health insurance coverage? Yes No
If "Yes", please provide the name and contact information of the employer and explain why you are not eligible for the employer provided coverage. _____

If you answered "Yes" to any of the above, please provide a brief explanation of the coverage provided and if the coverage is still in force. _____



SECTION D – PAYMENT INFORMATION

(OTHRP does not accept premium payments from employers or health care providers):

- 1. Is your employer or your family member’s employer, paying, contributing to, or reimbursing you for your Oklahoma Temporary High Risk Pool Premiums? Yes No
If yes, please provide the name and contact information of the employer _____
- 2. Is any Organization or Health Care Provider paying, contributing to, or reimbursing you for your Oklahoma Temporary High Risk Pool Premiums? Yes No
If Yes, please provide the name and contact information of the organization or health care provider: _____

SECTION E – ELIGIBILITY

Are you eligible for, or currently covered under COBRA? Yes No If “Yes”, provide dates of coverage: _____

I am eligible for coverage with OTHR for the following reason(s):

- I have a pre-existing medical condition** (You must provide a signed physician’s statement. See Pre-Existing Medical Conditions Requirement.)
- I received a denial letter from an insurance company in Oklahoma.** (You must provide a copy of the insurance company’s denial letter.)
- I received an offer of coverage from an insurance company in Oklahoma that has a rider that doesn’t cover my medical condition.** (You must provide a copy of the insurance company’s rider that doesn’t cover your medical condition.)
- I received an offer of coverage from an insurance company in Oklahoma that included a rating of 125 percent, or greater, than the insurance carrier’s standard rate.** (This condition of eligibility is only applicable to children under the age of 19 who have a pre-existing medical condition. You must provide a copy of the insurance company’s offer of coverage)

APPLICANT’S SIGNATURE (AGE 16 AND OVER) <i>(Parent or Legal Guardian’s Signature for children under 16)</i>	DATE SIGNED
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SECTION F - HOUSEHOLD INCOME INFORMATION

Providing the following information will not disqualify an applicant from OTHR eligibility, and will aid a determination of eligibility for other state-administered health care insurance coverage.

- 1. The number of individuals living at your residence is _____
- 2. The annual gross household income is _____

SECTION G - REFERRAL TO THE OKLAHOMA TEMPORARY HIGH RISK POOL

This section is not required if the application is being completed by an agent.

Please tell us how you heard about the Oklahoma Temporary High Risk Pool, such as through a friend/relative, television/newspaper/radio advertisement, or perhaps a doctor/hospital. Your input is valuable and will help us make informed decisions on the best way(s) to distribute important information about the Oklahoma Temporary High Risk Pool to interested Oklahomans.



SECTION H – AGENT INFORMATION *(if applicable)*

It is not required that you have an insurance agent involved in this application process for OTHRP, so you can leave blank the agent’s statement below. However, if an agent assists in the process, please ask the agent to complete the following statement.

Agent’s Statement: I have a valid agent’s or broker’s license in the state of Oklahoma for accident and health insurance. I have assisted the applicant in completing this application for coverage with OTHRP. To the best of my knowledge and belief, the information contained in the application and this affirmation form is correct and complete. I certify that the applicant meets the OTHRP eligibility standards.

The following information must be completed by the Agent:

AGENT NAME (REQUIRED - PLEASE PRINT)		AGENT LICENSE # (REQUIRED)		AGENT SSN (REQUIRED IF PAYING AGENT)	
AGENT MAILING ADDRESS: Number, Street (REQUIRED)			CITY	STATE	ZIP CODE
AGENT PHONE					
AGENT SIGNATURE (REQUIRED)				SIGNATURE DATE (REQUIRED)	

AGENCY: (THIS SECTION IS **ONLY** REQUIRED IF PAYEE IS THE AGENCY)

LEGAL NAME OF AGENCY (PAYEE)			AGENCY FEDERAL TAX ID		
AGENCY MAILING ADDRESS: Number, Street (IF DIFFERENT THAN ABOVE)			CITY	STATE	ZIP CODE

APPLICANT'S DISCLOSURE AUTHORIZATION AND DECLARATION



I declare that no person named in this application is currently covered by an Oklahoma Temporary High Risk Pool policy. The foregoing statements and answers are full, complete, and true to the best of my knowledge and belief; and any coverage issued will be in full reliance upon this representation. I understand and agree that no coverage shall be effective until all requirements have been completed. I understand and agree to pay an application fee equal to the premium mode I have selected. This payment is only a deposit that will be returned if my application is denied or applied to any premium charges if my application is accepted. I understand and agree that the deposit of my application fee does not constitute acceptance of my application by the Oklahoma Temporary High Risk Pool. I understand and agree that referring agents are not authorized to interpret, amend, or alter the terms of the Oklahoma Temporary High Risk Pool policy, nor are referring agents authorized to bind Oklahoma Temporary High Risk Pool in any way. I understand and agree that premiums charged for coverage and the coverage provided by the Oklahoma Temporary High Risk Pool are subject to change by the OTHRP Board of Directors.

I understand that if approved for coverage, my Oklahoma Temporary High Risk Pool premiums may not be paid or reimbursed, directly or indirectly, by a health care provider or by my employer, if employer currently offers health insurance coverage.

I understand that if approved for coverage, I will report changes in my employment status (or that of a family member) during the time that I am covered by the Oklahoma Temporary High Risk Pool.

I understand that my coverage will not become effective until approval of my application by the Oklahoma Temporary High Risk Pool.

I permit any physician, pharmacist, hospital or other health care provider, insurer, prepayment organization or other health plan provider to give the Oklahoma Temporary High Risk Pool, the Administrator or its designated representative any medical information about me, including information about physical and mental health, medical history and drug or alcohol use. This information will be used to evaluate my eligibility for the Oklahoma Temporary High Risk Pool policy and claims for benefits. A reproduction of this authorization shall be as valid as the original.

I have read the above statement, and I agree to supply the data on this form with full knowledge of the information provided in that statement. If I am applying based on an agent's certification of my ineligibility for substantially similar coverage from an insurer or health maintenance organization, based on my medical condition(s), I hereby certify that the medical information provided on this application by the agent is correct.

I know that any fraudulent misstatements or omissions, or intentional misrepresentations of a material fact that are made on this application, or any act or practice that constitutes fraud, will result in the cancellation of coverage retroactive to the effective date of coverage subject to prior notification. I also know that any material misstatements or omissions of information that are made on this application may be the basis for later denial of a loss incurred during my coverage.

I understand that this authorization shall remain valid for no more than twenty-four (24) months from the date of my signature below and that I may revoke this authorization at any time by sending a written notification of revocation to the Executive Director of the Oklahoma Temporary High Risk Pool at PO Box 50429, Midwest City, OK 73140.

SIGNATURE OF APPLICANT X	DATE	SIGNATURE OF CUSTODIAL PARENT (IF APPLICANT IS UNDER AGE 16) X	DATE
PRINT APPLICANT NAME		PRINT CUSTODIAL PARENT NAME (IF APPLICABLE)	



TOBACCO USE AFFIDAVIT

This form is used to determine your premium rate. You are only eligible for the lower non-tobacco user rate after you certify that you have been tobacco-free during the prior 12 months.

NAME	SOCIAL SECURITY NUMBER / MEMBER ID NUMBER
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TOBACCO USE INFORMATION

Check the applicable box below

I have used tobacco products during the prior 12 months.

Yes No

NOTE: Tobacco products include cigarettes, cigars, chewing or pipe tobacco or any other tobacco products regardless of the frequency or method of use.

By signing this form, I certify the following:

1. I have truthfully checked the Yes or No box above that accurately reflects my use of tobacco products in the prior 12 months.
2. I understand that tobacco products include cigarettes, cigars, chewing or pipe tobacco or any other tobacco products regardless of the frequency or method of use.
3. I understand that if I currently use tobacco products and stop using tobacco products in the future, I will be eligible for the lower non-tobacco user rate the month following OTHRP's receipt of a new Tobacco Use Affidavit certifying that I have not used tobacco products during the prior 12 months.
4. I understand that if I fail to complete this Affidavit truthfully, OTHRP may adjust my premium charges retroactively for the applicable higher tobacco-user rate. Upon written notification, I must reimburse OTHRP any amounts reduced from my premiums for the period for which I falsely certified eligibility for the non-tobacco user rate.
5. I understand that if I state on this form that I do not use tobacco products, I may be asked at a later date to supply a certification from my physician that I am not a tobacco user.

SIGNATURE	DATE SIGNED
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PRE-EXISTING MEDICAL CONDITIONS REQUIREMENT FOR ADULTS AND CHILDREN

To document the presence of a pre-existing medical condition, OTHRP requires a letter on the physician's letterhead, signed and dated within the past 12 months by the individual's physician, verifying:

- The individual previously had, or currently has, a medical condition(s)
- The medical condition(s)
- The physician's contact information and medical license number

AUTHORIZATION AGREEMENT FOR MONTHLY AUTOMATIC BANK DEDUCTION OF INSURANCE PREMIUM



Complete and sign the Authorization Agreement for monthly Automatic Bank Deduction of Insurance Premium if you have chosen monthly payments. Please note:

- Attach a sample of your check marked "VOID".
- Verify your account number with your banking institution. (Frequently, the account number listed on a check includes or removes digits from the actual account number.)

As a convenience to me (or us, if this is a joint account), I (we) hereby request and authorize you to pay and charge to my (our) account, checks or electronic debits drawn on my (our) account by you and payable to the order of the Oklahoma Temporary High Risk Pool. I (we) agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me (us). This authority is to remain in effect until revoked by me (us) in writing and until you actually receive such notice. I (we) agree that you shall be fully protected in honoring any such check or electronic debit.

I (we) further agree that if any such check or electronic debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

NAME OF ACCOUNT HOLDER(S)		SOCIAL SECURITY NUMBER	MONTHLY WITHDRAWAL DATE			
			FIRST FRIDAY	SECOND FRIDAY	THIRD FRIDAY	FOURTH FRIDAY
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BANK NAME	ACCOUNT NUMBER	ACCOUNT TYPE	ROUTING NUMBER			
		CHECKING <input type="checkbox"/>	SAVINGS <input type="checkbox"/>			
BANK ADDRESS	CITY	STATE	ZIP			

Signature of Account Holder(s)

NAME (PLEASE PRINT)		NAME (PLEASE PRINT)	
SIGNATURE	DATE	SIGNATURE	DATE

ATTACH A VOIDED CHECK HERE

The voided check must match the account number given on this form.
A deposit ticket will not be accepted.

To The Financial Institution named: In consideration of your participating in a plan which the Oklahoma Health Insurance High Risk Pool ("Company") has put into effect by which amounts due on policies of insurance are collected by checks drawn or pre-authorized electronic debits originated by the Company on the accounts of persons who are responsible for these payments, the Company does hereby agree that:

- (1) It will indemnify and hold you harmless from any liability to any person arising out of the payment by you of any check or electronic debit, whether or not genuine, originated by the Company in the regular course of business for the purpose of payment, or arising out of the dishonor by you whether with or without cause, or intentionally or inadvertently, of any such check or electronic debit, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy of insurance the premium on which is sought to be collected by the Company by any such check or electronic debit; and
- (2) Without limitation on the foregoing indemnities, it will refund to you any amount erroneously paid by you on any such check or electronic debit if claim for the amount of such erroneous payment is made by you within six months from the date of the check or electronic debit on which such erroneous payment was made; and
- (3) Your participation in the plan or that of the depositor may be terminated by written notice from either party to the other, likewise, your participation and that of the Oklahoma Temporary High Risk Pool may be terminated by 30 days written notice from either party to the other.

Oklahoma Temporary High Risk Pool authorized in a resolution adopted by the Board of Directors.