



Health Insurance Risk-Sharing Plan APPLICATION FOR COVERAGE - FEDERAL

SECTION 1. INSTRUCTIONS

THIS APPLICATION IS FOR THE HIRSP FEDERAL PLAN ONLY.

To be considered for the Health Insurance Risk-Sharing Plan (HIRSP) Federal Plan coverage, applicants are required to:

1. Answer *all* questions completely to permit HIRSP to process the application. In order to process the application, HIRSP needs the applicant's Social Security Number and certain other personally identifiable information. The personally identifiable information and Social Security Number will be kept confidential and used only in our administration of the HIRSP programs, as authorized by Chapter 149, Wisconsin Statutes and federal law.
2. Submit separate applications and separate premium payments for each applicant, see Section 13.
3. Submit supporting documentation required to process the application.
4. To receive additional information regarding the HIRSP Federal Plan, visit: www.hirsp.org or call 1-888-253-2698

SECTION 2. APPLICANT INFORMATION

THIS APPLICATION IS FOR THE HIRSP FEDERAL PLAN ONLY.

2A. Last Name	First	Middle	2B. Gender <input type="checkbox"/> M <input type="checkbox"/> F	2C. Telephone Number ()
2D. Street Address	City	State	ZIP Code	2E. Date of Birth (MM/DD/YYYY)
2F. Social Security Number 	2G. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
2H. Email Address _____				
2I. How did you hear about the Health Insurance Risk-Sharing Plan (HIRSP)?				
<input type="checkbox"/> Private Insurer (e.g. letter of rejection)	<input type="checkbox"/> Insurance Agent	<input type="checkbox"/> Employer		
<input type="checkbox"/> Referral from Government Agency	<input type="checkbox"/> Newspaper or Periodical	<input type="checkbox"/> Radio		
<input type="checkbox"/> Online/Internet	<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Other _____		

SECTION 3. ELIGIBILITY

You must be a resident of the State of Wisconsin to be eligible for the HIRSP Federal Plan. You must show Wisconsin as your legal residence by submitting a copy of at least one of the following: a valid Wisconsin driver's license, registration to vote in Wisconsin, and/or a Wisconsin income tax return. A child is a resident if the child lives in this state and at least one of the child's parents or legal guardian meets the above residency requirements. A person with a disability that prevents him or her from obtaining a Wisconsin driver's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return is a resident if the person's permanent physical address is in this state.

- 3A. Have you been uninsured for at least 6 months? (*must complete section 8*)..... Yes No
- 3B. Are you a resident of Wisconsin? Yes No
- 3C. Do you have a pre-existing condition? (*must complete section 7*)..... Yes No
- 3D. Are you a US Citizen or legally present in the United States? Yes No
(Refer to the checklist on page 7 for required documentation)

Note: If you answered "No" to any of the questions 3A-3D, you are not eligible for this HIRSP Federal Plan. You may be eligible for Wisconsin HIRSP. To apply for WI HIRSP visit www.hirsp.org or contact HIRSP Customer Service at 1-800-828-4777 for an application.

For more information about the HIRSP Federal Plan, visit our Web site at www.hirsp.org

SECTION 4. OTHER FAMILY MEMBERS ENROLLED IN THE HIRSP FEDERAL PLAN

4A. The HIRSP Federal Plan offers a family out-of-pocket cost maximum if a family has more than one member in the **same** HIRSP Federal Plan. Is another person in your family applying for or insured under the HIRSP Federal Plan? Yes No

If you answered "Yes" to 4A above, complete 4B, 4C, 4D, and 4E below for each family member applying for or insured under the HIRSP Federal Plan. Attach extra pages to this application if you need more room. Remember that a separate application, supporting documentation, and premium payment must be submitted for each person applying for HIRSP coverage.

4B. Name of family member applying or enrolled in the HIRSP Federal Plan

4C. Relationship to You	4D. Check One <input type="checkbox"/> Already on HIRSP <input type="checkbox"/> Applying for HIRSP
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4E. Policy Number _____

SECTION 5. EMPLOYER HEALTH COVERAGE

To be eligible for the HIRSP Federal Plan, you cannot be enrolled in other insurance coverage in the six months prior to your HIRSP Federal Plan effective date, including employer-sponsored group coverage. Fill in the information requested in 5A through 5E below for the applicant (or parent, legal guardian or other legally responsible adult for the applicant if applicant is a dependent child), and, if applicable, spouse (or other parent if the applicant is a dependent child). **HIRSP will contact any employers listed on this application for the purpose of verifying employment and insurance information.**

	APPLICANT	SPOUSE
5A. Employment Status	<input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time _____ Hours/Week <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed	<input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time _____ Hours/Week <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed
5B. Does your employer offer health coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, why are you (your dependent) not covered on your employer-sponsored health coverage?		
5C. Employer Name		
5D. Employer Address		
5E. Employer Phone Number		

SECTION 6. WISCONSIN MEDICAID COVERAGE

To be eligible for the HIRSP Federal Plan, you generally cannot be enrolled in Wisconsin Medicaid or BadgerCare Plus.

- 6A. Are you enrolled under Wisconsin Medicaid or BadgerCare Plus? Yes No
- 6B. If you are currently covered by Wisconsin Medicaid or Badger Care Plus, please provide your effective date (MM/DD/YYYY) | | | | | | | | | |
- 6C. If this coverage is terminating, or has been terminated, please provide your termination date (MM/DD/YYYY)..... | | | | | | | | | |
- 6D. Provide your 10-digit Medicaid or BadgerCare Plus number. | | | | | | | | | |

SECTION 7. EVIDENCE OF PRE-EXISTING CONDITIONS

To be eligible for the HIRSP Federal Plan, you must answer “yes” to **at least** one of the following questions. The HIRSP Federal Plan does NOT apply a waiting period for pre-existing conditions.

- 7A. In the past 5 years, have you been treated or diagnosed with a condition listed in Addendum A (page 7) . Yes No
Please list the condition(s) _____
- 7B. In the past nine months, did you receive a notice of rejection due to health reasons from an insurer? Yes No
- 7C. In the past nine months, did you receive a notice of reduction or limitation of coverage, including restrictive riders, due to health reasons from an insurer? Yes No
- 7D. In the past nine months, did you receive a notice of an increase in your premium of 50% or more due to health reasons?..... Yes No
- 7E. In the past nine months, did you receive two or more offers for insurance with premiums at least 50% higher than what you would be charged for a standard individual policy with substantially the same coverage and deductibles as HIRSP due to health reasons?..... Yes No

If you answered “Yes” to question 7A, please attach to your application a letter from a licensed physician dated within the last 9 months listing a medical condition from Addendum A; OR

If you answered “Yes” to any of 7B-7E, please attach to your application a copy of the notice(s) from your insurance company(ies) of rejection, reduction or premium increases.

SECTION 8. PREVIOUS MEDICAL COVERAGE

In order to verify eligibility for the HIRSP Federal Plan, please answer the following questions.

- 8A. Have you ever had health insurance?..... Yes No
(If you answered “yes” complete 8B, 8C and 8D. If you answered “no” complete 8D)
- 8B. Your previous medical plan was a(n)
 Continuation coverage or COBRA Group health coverage offered through an employer
 Individual medical plan Other _____
- 8C. Provide the following information for your previous medical plan.

Name of Insurance Company	Telephone Number
Policy Identification Number	Effective Date (MM/DD/YYYY)
	Termination Date (MM/DD/YYYY)

- 8D. Provide a brief explanation for losing your medical coverage or why you have not been covered by a medical plan.
- _____
- _____
- _____

SECTION 9. CHOICE OF HIRSP PLANS

The HIRSP Federal Plan offers four coverage options, which are summarized in the HIRSP Federal Plan Options Table on page 8 of this application. For more details refer to the HIRSP Outline of Coverage for an explanation of available plans and benefits. Your application cannot be processed if you do not choose a plan.

9A. This application is for the following HIRSP Federal Plan (choose one only):

- Federal 500** (\$500 Deductible)
(Lowest Deductible, Highest Premium)
- Federal 1,000** (\$1,000 Deductible)
(Lower Deductible, Higher Premium)
- Federal 2,500** (\$2,500 Deductible)
(Higher Deductible, Lower Premium)
- Federal 3,500** (\$3,500 Deductible)
(Highest Deductible, Lowest Premium)

SECTION 10. HOUSEHOLD INCOME

Provide your household income.

10A. My annual household income is \$ _____ (All income reportable for Wisconsin tax purposes and all the items identified on Wisconsin Homestead Credit-Schedule H, less a deduction of \$250 for each qualifying dependent.)

If your annual household income is less than \$34,000, you may qualify for reduced premium and deductible in the **Wisconsin HIRSP** plans. For more information on **Wisconsin HIRSP** visit www.hirsp.org or call 1-800-828-4777.

SECTION 11. HEALTH HISTORY

First, please list any injuries or illnesses that you were diagnosed with; or medical advice, care, or treatment that was recommended in the past six months. _____

11A. Do you currently have diabetes?..... Yes No

11B. If yes, would you be interested in receiving additional information and assistance with your diabetic care? Yes No

SECTION 12. HIRSP EFFECTIVE DATE

Your effective date will be the first of the month, following the month the HIRSP Federal Plan receives your completed application. This includes supporting documentation and the full amount of your first premium payment.

SECTION 13. YOUR PREMIUM AND PAYMENT AUTHORIZATION

Advance premium deposit must be submitted with this application. The amount of your deposit is dependent on the payment option selected below. If you elect to make quarterly premium payments, your deposit is equal to the quarterly premium. If you elect to make monthly premium payments via ACH or credit card, your premium deposit is equal to the monthly premium.

Your premium amount is \$ _____ (refer to Premium Rate Table).

Please check the mode of payment you're requesting in either A., B. or C. below

- A. **AUTOMATIC WITHDRAWAL.** We electronically transfer your premium directly from your bank account at the frequency you request. If you do not submit your initial premium payment with your application, we will withdraw this payment from your bank account upon the approval of your application. (If you select this option, please complete the Automatic Withdrawal Payment Authorization Form on page 6.)
 Monthly Quarterly
- B. **CREDIT/DEBIT CARD.** If you do not submit your initial premium payment with your application, we will charge your credit card this payment upon the approval of your application. (If you select this option, please complete the Credit/Debit Card Authorization Form on page 6.)
 Monthly Quarterly
- C. **DIRECT BILL.** We send a premium notice directly to your home. You must return payment to HIRSP by the premium due date.
 Quarterly

SECTION 14. AGENT INFORMATION

If an insurance agent provided you with this application form, helped you complete and submit the application, and your application is approved, HIRSP will reimburse the agent for his or her time. Have the agent complete the following section.

Signature – Agent	Date Signed
Name – Agent (Print)	
Wisconsin Insurance License Number	
Tax Identification Number / Social Security Number	
Name – Agency	
Street Address	
City, State, ZIP Code	
Telephone Number	
<input type="checkbox"/> Checking this box authorizes HIRSP to release all information regarding the application and eligibility determination to the agent listed above for up to 60 days following receipt of this application.	

SECTION 15. CERTIFICATION AND SIGNATURE

I certify that the foregoing answers are true and accurate to the best of my knowledge and belief. I understand that no coverage will be effective until I pay the full amount of the premium for coverage and HIRSP approves this application. I understand that I am subject to disenrollment and possible prosecution under state and federal laws if this information is false. I will notify HIRSP in writing (PO Box 8961, Madison, WI 53708-8961) of any change of name, income, insurance, employment status, address, or telephone number. **I agree to allow HIRSP to contact any employers and insurers listed on this application for the purpose of verifying employment and insurance information.** I understand I am responsible for all medical costs of services not covered by the HIRSP Federal Plan. I am hereby informed of my rights to appeal a denial of eligibility.

SIGNATURE — Applicant	Date Signed
SIGNATURE — Parent or legal guardian if applicant is under age 18 or legally incompetent.	Date Signed
PRINT NAME — Parent or legal guardian	

Refer to the Checklist section on page 8 to make sure your application is complete.

NOTE: This conditional receipt is issued with the understanding that, while your application is going through processing, your payment will be cashed, however you will not be covered until your eligibility is determined and you are approved. Upon receipt of your application, you will receive an acknowledgement letter from HIRSP within 14 days. Contact HIRSP at 1-800-332-0903 if you do not receive this letter within this timeframe.

AUTOMATIC WITHDRAWAL PAYMENT AUTHORIZATION FORM**A. ACCOUNT HOLDER INFORMATION**

Name _____

HIRSP Member Number (if available) _____

Address _____

City, State, Zip _____

Payment Mode:Select One: Monthly Quarterly**B. FINANCIAL INSTITUTION INFORMATION**

Institution Name _____ Branch/Location _____

Address _____

City, State, Zip _____

Select One: Checking Account Savings Account

Please indicate the date in which you wish to have your premium payment withdrawn from your account _____

Transit Number _____ Account Number _____

By my signature below, I authorize the Health Insurance Risk-Sharing Plan (HIRSP) to instruct my financial institution to deduct my premium payments from the account designated below. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify HIRSP in writing of its termination. My notification must afford HIRSP and my financial institution reasonable opportunity to act on it.

Applicant's Signature (Please sign in black ink)_____
Date**CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM****A. Applicant Information**

Name _____

HIRSP Member Number (if available) _____

B. Billing Information, if different than applicant

Name as it Appears on Credit/Debit Card _____

Mailing Address _____

City, State, Zip _____

C. Premium Payment ModeSelect One: Monthly Quarterly

Please indicate the day in which you wish to have your premium payment withdrawn from your account _____

D. Credit/Debit Card AuthorizationSelect One: Visa MasterCard Discover Card_____
Credit/Debit Card Number_____
Card Expiration Date

By signing below you authorize HIRSP or its authorized credit/debit card transaction agent(s) to bill the credit/debit card account indicated above for payment of premiums charged for the HIRSP policy for which you are applying. You understand and agree that by executing this authorization, that action doesn't affect, waive, or change any of the policy's terms, conditions, and provisions, including that policy's premium payment and grace period provisions.

Applicant's Signature (Please sign in black ink)_____
Date

ADDENDUM A
HIRSP FEDERAL QUALIFYING HEALTH CONDITION LIST

If you have been treated or diagnosed within the last 5 years with one of the conditions listed below, please submit a letter from a licensed physician dated within the last 9 months confirming your treatment or diagnosis.

<ul style="list-style-type: none"> • AIDS/HIV • Alzheimer's Disease/Dementia • Alcohol or Drug Abuse • ALS, Lou Gehrig's Disease • Amnesia • Aneurysm • Angina Pectoris • Aphasia • Anorexia • Aplastic Anemia • Ascites • AV Block • Barrett's Esophagus • Bechet's Syndrome • Bi polar Disorder • Bone Marrow Transplant • Buerger's Disease • Brain Disorders (abscess, chronic brain syndrome, tumors, brain injury) • Bulimia • Cardiomyopathy • Cancer • Celiac Sprue Disease • Cerebral Palsy • Cerebral Vascular Accident (CVA) • Chronic Pancreatitis • Cirrhosis of the Liver • Congestive Heart Failure • COPD • Coronary Artery Disease • Crohn's Disease • Cystic Fibrosis • Dermatomyositis • Diabetes • Dialysis • Down's Syndrome • Emphysema • Enlargement of the heart • Epilepsy with a seizure within the last 5 years • Factor IV • Farmer's Lung • Fibromyalgia • Friedreich's Ataxia • Gilbert's Syndrome • Guillain-Barre Syndrome • Heart attack • Hemophilia • Hepatitis A, B or C • High cholesterol levels 	<ul style="list-style-type: none"> • Hodgkin's Disease • Huntington's Chorea • Hydrocephalus • Hysterectomy • Ischemic Heart Disease • Left Bundle Branch Block • Leukemia • Liver Disease or disorders (Abscess, Cirrhosis, Enlarged, Fatty Liver, elevated liver enzyme levels) • Lupus • Marfan Syndrome • Mental Retardation • Morbid Obesity • Multiple Sclerosis • Muscular Dystrophy's • Myasthenia Gravis (MG) • Myotonia • Obsessive-Compulsive Disorder • Organ Transplants • Osteogenesis Imperfecta • Osteoporosis • Pacemaker • Paraplegia/Quadriplegia • Parkinson's • Palsy • Panic Disorder • Peripheral Vascular Disease • Pick's Disease • Pregnancy • Psychotic Disorder • Quadriplegia • Renal Failure/Renal Insufficiency • Retinitis Pigmentosa • Rheumatoid Arthritis • Schizophrenia • Scleroderma • Seizure • Sickle Cell Anemia • Sinus Bradycardia or Tachycardia • Sleeping disorder • Stroke • Suicide Attempt • Syringomyelia • Tourette's Syndrome • Transient Ischemic Attack (TIA) • Turner Syndrome • Ulcerative Colitis • Usher Syndrome • Wilson's Disease
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Note: If submitting a letter from a licensed physician identifying one of the conditions above, you do not need to submit a notice of rejection, reduction or premium increase from an insurance company (refer to Section 7).

CHECKLIST

You must remember to provide the following information with your application.

Wisconsin Residency (all applicants)

- Attach either a copy of your driver's license, documentation of voter registration, and/or Wisconsin income tax return.

Citizenship (all applicants)

Attach a copy of one of the following documents

- WI Driver License
- WI Identification Card
- US Passport or US Passport Card
- Permanent Resident Card or Alien registration Receipt Card (Form I-551)
- Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
- Employment Authorization Document that contains a photograph (Form I-766)
- In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired
- Passport from the Federated states of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI

Medical Condition

Attach one of the following documents to support your eligibility based on a medical condition.

- Letter identifying medical condition from a licensed physician.
- Notice of rejection of coverage from an insurer
- Notice of significant reduction in coverage or limitation of coverage, including restrictive riders, due to health reasons
- Notice of increase in premium of 50%
- Two or more offers of insurance with premiums at least 50% higher than what you would be charged for a standard individual policy with substantially the same coverage and deductibles as the HIRSP Federal Plan.

Other Required Information

- Include separate checks, if applicable, and applications for each applicant.
- If you have selected Automatic Withdrawal, your premium payments will be automatically deducted from your account either monthly or quarterly depending on your selection.
- If you have selected Credit Card, your premium payments will be automatically charged to your credit card either monthly or quarterly, depending on your selection.
- If you have selected Direct Billing, include a check for the full amount of your premium. You will then be billed for your premium payments. You must submit these payments to HIRSP via check or money order.
- Disclosure Statement—If you wish to authorize HIRSP to release your personal health information, including premium billing or claims billing, to another individual (spouse, other family member, or insurance agent) complete the HIPAA Privacy Authorization for Use or Disclosure Form, found online at www.hirsp.org, at the time of your enrollment to avoid service delays or call 1-888-253-2698 to have a form mailed to you.

Mail your completed application, payment (if Direct Bill), and required documentation to: HIRSP at 1751 W Broadway, PO Box 8961, Madison, WI 53708-8961 or Fax: (608) 243-6136. If you have questions about this application, call HIRSP Federal Plan customer service at 1-888-253-2698 or 1-608-221-5315.

Failure to comply with all application requirements may delay the effective date for your coverage under the HIRSP policy.

For more information about the HIRSP Federal Plan, visit our Web site at www.hirsp.org

HIRSP FEDERAL PLAN OPTIONS TABLE

	Federal 500	Federal 1,000	Federal 2,500	Federal 3,500
Medical Deductible	\$500 per year	\$1,000 per year	\$2,500 per year	\$3,500 per year
Medical Coinsurance	20% of allowed amount up to \$1,000 total per year	20% of allowed amount up to \$1,000 total per year	20% of allowed amount up to \$1,000 total per year	20% of allowed amount up to \$1,000 total per year
Medical Out-of-Pocket Maximum*	\$1,500 per year	\$2,000 per year	\$3,500 per year	\$4,500 per year
Drug Copay/ Coinsurance	\$5 Tier 1 / \$45 Tier 2 up to a maximum \$2,000 per year	\$5 Tier 1 / \$45 Tier 2 up to a maximum \$2,000 per year	\$5 Tier 1 / \$45 Tier 2 up to a maximum \$2,000 per year	\$5 Tier 1 / \$45 Tier 2 up to a maximum \$1,450 per year

*Note: Medical out-of-pocket only applies to services covered under the HIRSP Federal Policy

HEALTH INSURANCE RISK-SHARING PLAN (HIRSP)

PO BOX 8961 • MADISON, WI 53708-8961

CUSTOMER SERVICE: (888) 253-2698 OR (608) 221-5315 FAX: (608) 226-8770

Grievance procedures for applicants and members

If HIRSP denies an application or claim payment, the applicant or member will receive directly from HIRSP a written notice of the denial, together with the specific reason for the denial.

An individual may request a review if he or she disagrees with HIRSP's decision to:

- (1) Deny or terminate coverage.
- (2) Deny or reduce payment of a claim.
- (3) Deny an application for a subsidy of HIRSP deductible and/or premium.

HIRSP will not consider requests to review across-the-board premium rate increases. These rates are set based on HIRSP's budgetary requirements and conditions as established by state law.

A member may request a review of the actions listed above according to the following procedure.

Grievance by Plan Administrator

If the member or applicant disagrees with HIRSP's decision, the individual may request a review by the plan administrator.* To request the review, the member must submit a written request including pertinent information such as name, identification number, date and place of service, and reason for the review.

Clearly indicate that the written request is for a review. This will help HIRSP process the request.

Mail or fax the grievance to:

HIRSP Grievance Committee
1751 W. Broadway
PO Box 7062
Madison, WI 53707-7062
Fax: (608) 223-3603

Upon receiving the request, the plan administrator will review the decision and either affirm, modify or rescind it. The plan administrator will communicate this decision, and the reason for the decision, in a written response. The plan administrator has 30 days from receipt of a request for review to issue a letter of decision or a letter to the requester asking for more information.

Review by Appeal Committee

If the member or applicant disagrees with the plan administrator's decision on the grievance review, the individual may file an appeal. To file an appeal, the individual must submit a written request including pertinent information such as name, identification number, date and place of service, and reason for the grievance. The appeal must be submitted within 30 days after receiving the grievance decision letter.

Clearly indicate that the written request is an appeal. This will help the Appeal Committee process the request.

Mail or fax the appeal to:

HIRSP Authority
Attn: Appeal Committee
33 E. Main St., Suite 230
Madison, WI 53703
Fax: (608) 441-5776

Upon receiving the request, the Appeal Committee will review the decision and either affirm, modify or rescind it. The Appeal Committee will communicate this decision, and the reason for the decision, in a written response within 45 days from the receipt of the request for review.

*It is requested that grievances be submitted within 30 days after receiving the plan administrator's decision.