

SECTION 4. OTHER FAMILY MEMBERS ENROLLED IN HIRSP

4A. HIRSP offers a family out-of-pocket cost maximum if a family has more than one member in the same HIRSP plan. Is another person in your family applying for or insured under HIRSP? 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 HIRSP. 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 HIRSP

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 HIRSP, you cannot be eligible for insurance through an employer-sponsored group, government or church plan. 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"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time _____ Hours/Week
5B. Does your employer offer health coverage?	<input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed	<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 9. ELIGIBILITY DUE TO HEALTH REASONS

- 9A. In the past nine months, did you receive a notice of rejection due to health reasons from an insurer? Yes No
- 9B. In the past nine months, did you receive a notice of cancellation due to health reasons from an insurer? ... Yes No
- 9C. 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
- 9D. 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
- 9E. 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
- 9F. Have you tested positive for the Human Immunodeficiency Virus (HIV)?..... Yes No

If you answered "Yes" to at least one of the questions **9A through 9F**, you must attach to your application a copy of the notice(s) from your insurance company(ies) of rejection, reduction or cancellation, premium increases or documentation that you are HIV positive. If you qualify for HIRSP based on 9A-9F, you will be subject to a six month waiting period for coverage of pre-existing conditions.

SECTION 10. PREVIOUS ENROLLMENT IN HIRSP

If you were previously covered under HIRSP and voluntarily terminated your HIRSP coverage, you are not eligible for coverage until 12 months have elapsed. This 12-month requirement does not apply if you are eligible for HIRSP because you lost insurance through an employer-sponsored group, government or church plan and answered "Yes" to all questions in Section 8 of this application or terminated HIRSP coverage because you were eligible to receive Medicaid or BadgerCare Plus benefits.

- 10A. Have you ever been enrolled in HIRSP? Yes No
- 10B. If you answered "Yes" to 10A above, provide the following information:

Member Identification Number		Cancellation Month/Year	
Name at time of HIRSP Coverage			

SECTION 11. OTHER MEDICAL COVERAGE

- 11A. Have you recently been covered, or are you currently covered, by any other medical plan..... Yes No
- If you answered "Yes" to 11A above, complete 11B, 11C and 11D. If you answered "No," complete 11E.**

- 11B. Were you enrolled in another High Risk Pool for one year and are applying within 45 days of termination? Yes No
- If yes include a letter of Creditable Coverage from the other High Risk Pool. If you were enrolled in another state's high-risk pool for at least one year and are applying to HIRSP within 45 days of termination from that high-risk pool you will not be subject to the six month waiting period for coverage of pre-existing conditions. If you answer "yes" to 11B; skip to 11D.

- 11C. If you answer "No" to 11B your other medical plan is/was a(n)
 - Continuation coverage or COBRA
 - Individual medical plan
 - Group health coverage offered through an employer
 - Other _____

- 11D. Provide the following information for your other medical plan.

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

- 11E. If you answered "No" to 11A above, provide a brief explanation for not having medical coverage _____

SECTION 12. FOR HIRSP APPLICANTS WHO HAVE MEDICARE

- 12A. Are you eligible for Medicare? Yes No
If you answered "Yes" to 12A above, continue to question 12B.
If you answered "No" to 12A above, and are enrolling within 45 days of Medicare termination, complete question 12F, otherwise skip to Section 13. Yes No
- 12B. Are you enrolled in Medicare Part A, Part B, and Part D Yes No
If you are not enrolled in Medicare Part A, Part B, and Part D, you are not currently eligible for HIRSP. You will need to enroll in all three parts of Medicare to become eligible for HIRSP.
- 12C. Attach a copy of your Medicare card with this application and in the following space enter your Medicare Part A and Part B identification number:.....
- 12D. Attach a copy of your current Medicare Part D Prescription Drug Plan card with this application and in the following space enter your current Medicare Part D Prescription Drug Plan identification number:.....
- 12E. In the following space enter the effective date of your current Medicare Part D Prescription Drug Plan (MM/DD/YYYY):.....
- 12F. Provide your Medicare termination date, if applicable (MM/DD/YYYY).....
 Note: If you are applying within 45 days of losing your Medicare coverage and are subsequently found to be eligible for HIRSP coverage, the six month waiting period for coverage of pre-existing conditions will not apply.

SECTION 13. CHOICE OF HIRSP PLANS

HIRSP offers six coverage plans, which are summarized in the HIRSP Plan Options Table on page 10 of this application. For more details refer to the enclosed HIRSP Outline of Coverage for an explanation of available plans and benefits. Your application cannot be processed if you do not choose a plan. *Important! If you are eligible for Medicare you can only enroll in the HIRSP Medicare Supplement.*

13A. This application is for the following HIRSP plan (choose one only):

- | | | |
|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> HIRSP 1,000 (\$1,000 Deductible)
(Lower Deductible, Higher Premium) | <input type="checkbox"/> HIRSP Health Savings Account
(\$3,500 Deductible, HSA-Qualified Plan) | <input type="checkbox"/> HIRSP Medicare Supplement
ONLY available for applicants who are: <ul style="list-style-type: none"> • Younger than age 65 and eligible for Medicare due to a disability AND • Enrolled in Medicare Part A AND • Enrolled in Medicare Part B AND • Enrolled in Medicare Part D |
| <input type="checkbox"/> HIRSP 2,500 (\$2,500 Deductible)
(Higher Deductible, Lower Premium) | <input type="checkbox"/> HIRSP Health Savings Account
(\$2,500 Deductible, HSA-Qualified Plan) | |
| <input type="checkbox"/> HIRSP 5,000 (\$5,000 Deductible)
(High Deductible, Lowest Premium) | | |

SECTION 14. HOUSEHOLD INCOME AND FAMILY SIZE

Provide your household income and family size below.

- 14A. 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 \$500 for each qualifying dependent.)
 If your annual household income is less than \$34,000 a year, you may qualify for a reduced premium, deductible, and drug out-of-pocket maximum. Refer to the enclosed application for reduced premium, deductible, and drug out-of-pocket maximum or visit: www.hirsp.org or call 1-800-828-4777 for more information. Complete the application for reduced premium, deductible and drug out-of-pocket maximum and submit it with this application.
- 14B. My family size is _____ (Include yourself, spouse, and/or legal dependent children living in the same household).

SECTION 15. HEALTH HISTORY

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

- 15A. Do you currently have diabetes?..... Yes No
- 15B. If yes, would you be interested in receiving additional information and assistance with your diabetic care? Yes No

SECTION 19. 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 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 HIRSP. 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 9 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 1-888-527-0590 if you do not receive this letter within this timeframe.

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

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. I must notify HIRSP a minimum of 10 business days in advance of any changes to my account. I understand that my HIRSP premium will be pulled from my account the month prior to the billing due date.

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 _____
(Choose between the 7th and the 31st of the month)

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

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.

Lost Coverage from Employer (if you've answered "yes" to all questions in Section 8).

- Attach copies of your certificate(s) of creditable coverage, or other forms of proof of coverage.

Note: You do not need to submit proof of Medical Condition

Medical Condition (if you've answered "yes" to at least one question in Section 9)

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

- Notice of rejection of coverage from an insurer
- Notice of cancellation of coverage
- Notice of significant reduction in coverage
- 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 HIRSP
- Documentation that you are HIV positive

Lost Coverage from another High Risk Pool (if you've answered "yes" to question 11B)

- Attach a copy of your certificate of creditable coverage.

Medicare/Lost Coverage from Medicare (if you've completed Section 12)

- Copy of Medicare card
- Copy of Medicare Part D Prescription Drug Plan card
- Attach proof of Medicare termination, if applicable

Other Required Information

- Include separate checks and applications for each applicant.
- If you have selected Automatic Withdrawal and do not include your initial premium payment, we will withdraw this payment from your bank account upon the approval of your application. Subsequent premium payments will be automatically deducted from your account either monthly or quarterly depending on your selection.
- If you have selected Credit Card and do not include your initial premium payment, we will charge your credit card this payment upon the approval of your application. Subsequent premium payments will be automatically charged to your credit card either monthly or quarterly, depending on your selection.
- If you have selected Quarterly Direct Billing, include a check for the full amount of your quarterly premium. You will then be billed quarterly for your premium payments. You will submit these payments to HIRSP via check or money order.
- If your annual household income is less than \$34,000, submit a HIRSP Application for Reduced Premium, Deductible, and Drug Out-of-Pocket Maximum, including required documents (i.e. Federal and Wisconsin income tax returns), to determine if you qualify. Refer to the application in your information packet or go to www.hirsp.org.
- 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 Authorization Form, found online at www.hirsp.org, at the time of your enrollment to avoid service delays or call 1-800-828-4777 to have a form mailed to you.

Mail your completed application, payment, and relevant 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 customer service at 1-800-828-4777 or 1-608-221-4551.

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

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

HIRSP PLAN OPTIONS TABLE

	HIRSP 1,000	HIRSP 2,500	HIRSP 5,000	HIRSP HSA* \$2,500	HIRSP HSA* \$3,500	HIRSP Medicare Supplement**
Medical Deductible	\$1,000 per year	\$2,500 per year	\$5,000 per year	\$2,500 per year (combined medical/drug deductible)	\$3,500 per year (combined medical/drug deductible)	\$500 per year
Medical Coinsurance	20% of allowed up to \$1,000 total per year	20% of allowed up to \$1,000 total per year	20% of allowed up to \$1,000 total per year	20% of allowed amount (after deductible is met)	20% of allowed amount (after deductible is met)	None
Medical Out-of-Pocket Maximum	\$2,000 per year (does not include drug copay)	\$3,500 per year (does not include drug copay)	\$6,000 per year (does not include drug copay)	\$4,600 per year (includes drug coinsurance)	\$5,600 per year (includes drug coinsurance)	\$500 per year (does not include drug copay)
Drug Copay/Coinsurance	\$5 Tier 1 / \$55 Tier 2 / \$75 Tier 3 up to a maximum \$2,500 per year	\$5 Tier 1 / \$55 Tier 2 / \$75 Tier 3 up to a maximum \$2,500 per year	\$5 Tier 1 / \$55 Tier 2 / \$75 Tier 3 up to a maximum \$2,500 per year	20% of allowed amount (after deductible is met)	20% of allowed amount (after deductible is met)	\$5 Tier 1 / \$55 Tier 2 / \$75 Tier 3 up to a maximum \$1,750 per year

*HSA Plans offer tax savings but do not offer first dollar drug coverage

**HIRSP Medicare Supplement - must be enrolled in Medicare Part A, Part B, and Part D

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

HEALTH INSURANCE RISK-SHARING PLAN (HIRSP)

PO BOX 8961 • MADISON, WI 53708-8961

CUSTOMER SERVICE: (800) 828-4777 OR (608) 221-4551 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.

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