Health Insurance Risk-Sharing Plan

APPLICATION FOR COVERAGE

SECTION 1. INSTRUCTIONS

To be considered for the Health Insurance Risk-Sharing Plan (HIRSP) 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. Providing this information is voluntary. The personally identifiable information and Social Security Number will be kept confidential and used only in our administration of the HIRSP program, as authorized by Chapter 149, Wisconsin Statutes and federal law.
2. Submit separate applications and separate premium payments for each applicant.
3. Submit supporting documentation required to process the application.
4. To receive additional information regarding the HIRSP Plan, visit: www.hirsp.org or call 1-800-828-4777

SECTION 2. APPLICANT INFORMATION

If you are a parent, legal guardian, or other legally responsible adult for the applicant, and are completing this application for the applicant, provide your name ______________________________

2A. Last Name First Middle	2B. Gender ☐ M ☐ F	2C. Telephone Number ( ) —
2D. Street Address City	State ZIP Code	2E. Date of Birth (MM/DD/YYYY)
2F. Social Security Number (Optional-see section 1, #1)	2G. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated	

SECTION 3. RESIDENT ELIGIBILITY

Unless you lost insurance through an employer-sponsored group, government or church plan, or you were enrolled in another state High Risk Pool for one year and applying within 45 days of termination, you must be a resident of the State of Wisconsin for at least three months to be eligible for HIRSP. You must show Wisconsin is 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 a Wisconsin resident for at least three months as of the HIRSP effective date? (refer to section 16 for information on effective dates) .... ☐ Yes ☐ No

3B. Have you been a Wisconsin resident for less than three months and lost your insurance through an employer-sponsored group, government or church plan, or you were enrolled in another state High Risk Pool for one year and are applying within 45 days of termination? .... ☐ Yes ☐ No

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

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 ☐ Already on HIRSP ☐ Applying for HIRSP

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	☐ Employed Full-Time ☐ Employed Part-Time ________ Hours/Week ☐ Self-Employed ☐ Unemployed	☐ Employed Full-Time ☐ Employed Part-Time ________ Hours/Week ☐ Self-Employed ☐ Unemployed
5B. Does your employer offer health coverage?	☐ Yes ☐ No	☐ Yes ☐ 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 ELIGIBILITY

To be eligible for HIRSP, you generally cannot be eligible for Wisconsin Medicaid or BadgerCare Plus. If you apply for coverage under HIRSP within 45 days after losing Medicaid or BadgerCare Plus eligibility and are subsequently found to be eligible for HIRSP, your policy effective date will be the date your Medicaid or BadgerCare Plus coverage was terminated and the six-month waiting period for coverage of pre-existing conditions will not apply. Individuals eligible for BadgerCare Plus Benchmark or Core Plan are also eligible for HIRSP. Applicants under age 19 are required to provide documentation that you are not eligible for BadgerCare Plus Standard Plan. To determine if you may be eligible for Medicaid or BadgerCare Plus, please visit www.access.wisconsin.gov.

6A. Are you eligible for health benefits 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. REASON FOR APPLICATION

There are two ways to be eligible for HIRSP. You may be eligible because you lost your employer-sponsored group, government or church plan, or you may be eligible due to health reasons.

7A. Why are you applying for HIRSP?

You lost insurance through an employer-sponsored group, government or church plan within the last 63 days.. ☐ Yes ☐ No

If yes, do not complete section 9

You are applying due to health reasons... ☐ Yes ☐ No

If yes, do not complete section 8

SECTION 8. LOST INSURANCE THROUGH EMPLOYER-SPONSORED GROUP, GOVERNMENT, OR CHURCH PLAN

If you are applying for HIRSP because you lost insurance through an employer-sponsored group, government or church plan, you may not be subject to a six-month waiting period for coverage of pre-existing conditions. (A pre-existing condition is a condition, whether physical or mental, regardless of the cause, which was diagnosed or for which medical advice, care, or treatment was recommended or received during the six months immediately preceding the policy effective date.)

8A. Were you offered continuation coverage under your employer-sponsored group, government or church plan, including state continuation coverage or Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage? .... ☐ Yes ☐ No

8B. If offered continuation coverage under your employer-sponsored group, government or church plan, including state continuation coverage or COBRA, did you exhaust the coverage? .... ☐ Yes ☐ No

8C. Do you certify that this coverage was not canceled due to nonpayment, fraud, or misrepresentation of the facts on your application?.. ☐ Yes ☐ No

8D. Including this employer-sponsored group, government or church plan, have you had continuous insurance coverage for at least 18 months with no gap in coverage greater than 63 days? .... ☐ Yes ☐ No

8E. Are you applying to HIRSP within 63 days of losing insurance through an employer-sponsored group, government or church plan? .... ☐ Yes ☐ No

If you answered "Yes" to questions 8A through 8E, *you must attach to your application a copy of your certificate of creditable coverage (or other supporting documentation, e.g. explanation of benefits, health insurance ID card(s)) from past insurers or employers to document your 18 months of continuous coverage. A certificate of creditable coverage is a written certification of prior health coverage issued by the previous health plan. The certificate must identify the covered person and period of coverage.* ***Please skip to section 10.***

If you answered "No" to any of the questions 8A through 8E above, you may be eligible for HIRSP due to health reasons. Complete the next section on Eligibility Due to Health Reasons.

SECTION 9. ELIGIBILITY DUE TO HEALTH REASONS

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

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 significant reduction of coverage 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 the above requirements, you will be subject to a six-month waiting period for coverage of pre-existing conditions.*

9G. Were you enrolled in another High Risk Pool for one year and are applying within 45 days of termination? ☐ Yes ☐ No
Note: If yes include a letter of Creditable Coverage from the other High Risk Pool. You **must** have answered yes to one of the questions in 9A-9F.

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.

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:

Policyholder 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 and 11C. If you answered "No," complete 11D.

11B. Your other medical plan is/was a(n)

☐ Continuation coverage or COBRA ☐ Group health coverage offered through an employer
☐ Individual medical plan ☐ Other ______

11C. 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)

11D. **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 Section13.

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 due to loss of Medicare coverage and are within 45 days after termination 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 9 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):

☐ HIRSP 1,000 ($1,000 Deductible) (Lower Deductible, Higher Premium)

☐ HIRSP 2,500 ($2,500 Deductible) (Higher Deductible, Lower Premium)

☐ HIRSP 5,000 ($5,000 Deductible) (High Deductible, Lowest Premium)

☐ HIRSP Health Savings Account ($3,500 Deductible, HSA-Qualified Plan)

☐ HIRSP Health Savings Account ($2,500 Deductible, HSA-Qualified Plan)

☐ HIRSP Medicare Supplement
ONLY available for applicants who are:
- 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

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 $250 for each qualifying dependent.)

If your annual household income is less than $33,000 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. CHRONIC CONDITION MANAGEMENT

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 16. HIRSP EFFECTIVE DATE

The earliest date your coverage may be effective is the date HIRSP receives your completed application *and* the full amount of your first premium payment. You may not request an effective date more than 60 days after the date you sign this application. To honor your requested effective date, HIRSP must receive your full premium payment with your application. Your 6 month waiting period for coverage of pre-existing conditions, if applicable, begins on your effective date.

16A. Do you request an effective date later than the date HIRSP receives your completed application and premium?.......... ☐ Yes ☐ No

16B. **If you answered "Yes" to 16A above,** indicate your requested effective date (MM/DD/YYYY).......... __ __ / __ __ / __ __ __ __

SECTION 17. 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 select this option, please complete the Automatic Withdrawal Payment Authorization Form on page 8.)
☐ Monthly ☐ Quarterly

B. ☐ CREDIT/DEBIT CARD. (If you select this option, please complete the Credit/Debit Card Authorization Form on page 8.)
☐ Monthly ☐ Quarterly

C. ☐ DIRECT BILL. We send a premium notice directly to your home. You return payment to HIRSP by the premium due date.
☐ Quarterly

SECTION 18. 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 $40.00 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	

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

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

Health Insurance Risk-Sharing Plan
1751 W. Broadway – P.O. Box 8961 – Madison, WI 53708-8961
(800) 828-4777 or (608) 221-4551

AUTHORIZATION FORM
To Permit Use and Disclosure of Protected Health Information

PURPOSE OF THIS FORM: This Authorization Form is to be used when an individual wishes to give another person access to his or her health information. When completed, it will allow HIRSP to disclose your health information to, and receive it from, the person(s) stated on the form.

Your Name: ___________________________________ **Your Date of Birth:** _____/_____/___________
Month Day Year

Your Address: ____

HIRSP Member Number: ________________________ **Telephone:**________________________________

Section 1. Please provide the name of the persons or organizations that you are authorizing to receive your Protected Health Information from HIRSP.

Name: ____Date of Birth: ______________________________

Address: ____

Relationship: __ Spouse __ Child __ Parent __Other __________________________________
(If the person identified is a Power of Attorney (POA) or other legal representative who has paper work identifying their health care and insurance decision-making abilities on your behalf, please submit a copy of that paperwork along with this completed form to HIRSP for review.)

Section 2. Information To Be Used or Disclosed - REQUIRED SECTION

Check one box to describe the health information you are authorizing to be used or disclosed:

☐ ALL – Check if you wish to have all your health information disclosed to the person(s) named in Section 1 or to HIRSP, or :
☐ SPECIFIC – Check if you wish to have only the following specific health information about you disclosed to the person(s) named in Section 1 or to HIRSP (must write in specific information):

____

____

Section 3. Purpose Of The Use or Disclosure – REQUIRED SECTION

Check one box to indicate the purpose of the requested use or disclosure of your health information:
☐ Check if the disclosure is "at the request of the individual" (or individual's Personal Representative), or
☐ Check if the disclosure is only for the following specific purposes (must write in the specific purposes):

____

____

Section 4. Expiration and Revocation

Expiration: This authorization will expire as follows (complete one):

☐ On _________/__________/___________(MM/DD/YYYY)
☐ On occurrence of the following event (which must relate to the Member or to the purpose of the use or the disclosure being authorized.) ____

Right to Revoke: I understand that I may revoke all or part of this authorization at any time by giving written notice of my revocation to the Privacy Office information listed below. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before receiving my written notice of revocation.

HIRSP
Customer Services
PO Box 8961
Madison, WI 53708-8961

Section 5. Signatures

I, ____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to HIRSP. I understand that by signing this form, I am confirming my authorization that HIRSP may use or disclose to the person or organizations named in this form the health information described in this form. I also understand that HIRSP will not condition payment, enrollment, or eligibility for benefits in HIRSP on the signing of this authorization.

I understand that once the information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws and could be re-disclosed by the person or entity that receives it.

I am entitled to keep a copy of this form for my records.

Signature – Member | Date

____ ______________________________

If this authorization is signed by a personal representative on behalf of the member, provide a copy of the documentation to support the representation and complete the following:

Print Name of Personal Representative | Relationship to Member

____ ______________________________

Signature – Personal Representative | Date signed

____ ______________________________

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 Mode
Select One: ☐ Monthly ☐ Quarterly

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

D. Credit/Debit Card Authorization
Select 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.

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 9H)

- ☐ 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, include a check for the full amount of your monthly or quarterly premium. Subsequent premium payments will be automatically deducted from your account either monthly or quarterly depending on your selection.
- ☐ If you have selected Credit Card, include a check for the full amount of your monthly or quarterly premium. 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 $33,000, submit a HIRSP Application for Reduced Premium, Deductible, and Drug Out-of-Pocket Maximum 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 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 1-800-828-4777 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. 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	$10 Tier 1 / $40 Tier 2 up to a maximum $2,000 per year	$10 Tier 1 / $40 Tier 2 up to a maximum $2,000 per year	$10 Tier 1 / $40 Tier 2 up to a maximum $2,000 per year	20% of allowed amount (after deductible is met)	20% of allowed amount (after deductible is met)	$10 Tier 1 (generic)/ $40 Tier 2 (brand) up to a maximum $1,500 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 policyholders

If HIRSP denies an application or claim payment, the applicant or policyholder 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 policyholder may request a review of the actions listed above according to the following procedure.

Grievance by Plan Administrator
If the policyholder or applicant disagrees with HIRSP's decision, the individual may request a review by the plan administrator.*
To request the review, the policyholder 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 policyholder 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