



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. However, since HIRSP uses this information to determine eligibility, we cannot process the application without it. 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	2C. Telephone Number
			<input type="checkbox"/> M <input type="checkbox"/> F	() —
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		
		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		

SECTION 3. RESIDENT ELIGIBILITY

Unless you lost insurance through employer-sponsored group, government, or church plan, you must be a resident of the State of Wisconsin to be eligible for HIRSP. You are a resident if you live in this state for at least three months and Wisconsin is your legal residence. You must show Wisconsin is your legal residence by at least one of the following: a 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 15) Yes No
- 3B. Have you been a Wisconsin resident for less than three months and lost your insurance through employer-sponsored group, government, or church plan? 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. Refer to the table on page 9 of this application for more information. 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 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 (or parent if applicant is a dependent child)	SPOUSE (or other parent if applicant is a dependent child)
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 9. ELIGIBILITY DUE TO HEALTH REASONS

- 9A. Are you eligible for Medicare because of a disability? Yes No
- 9B. Have you tested positive for the Human Immunodeficiency Virus (HIV)?..... Yes No
- 9C. In the past nine months, did you receive a notice of rejection due to health reasons from two insurers? . Yes No
- 9D. In the past nine months, did you receive a notice of cancellation due to health reasons from an insurer? . Yes No
- 9E. In the past nine months, did you receive a notice of significant reduction of coverage due to health reasons from an insurer? Yes No
- 9F. 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
- 9G. 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 at least one of the questions 9A through 9G, you must attach to your application a copy of the notice(s) from your insurance company(ies) of rejection, reduction or cancellation, premium increases, Medicare card 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.

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 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 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. 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 a(n)
 - Continuation coverage or COBRA
 - Individual medical plan
 - Group health coverage offered through an employer
 - Other _____

11C. Provide the following information for your other medical plan.

Name of Insurance Company		Telephone Number	
Policy Identification Number		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?
12B. Are you enrolled in Medicare Part A, Part B, and Part D?
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):

SECTION 13. CHOICE OF HIRSP PLANS

HIRSP offers five 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 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 \$25,000 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. 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.

- 15A. Do you request an effective date other than the date HIRSP receives your completed application and premium?
15B. If you answered "Yes" to 15A above, indicate your requested effective date (MM/DD/YYYY):

SECTION 16. YOUR PREMIUM AND PAYMENT AUTHORIZATION

The advance premium deposit must be submitted with this application.

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

Select How You Want To Pay Your Ongoing Premiums

16A. **Automatic Withdrawal.** We electronically transfer your premium directly from your bank account monthly or quarterly (You will not receive a monthly billing statement with this option.)

Choose automatic withdrawal frequency Monthly Quarterly

Account Holder Information

Name _____

Address _____

Financial Institution Information

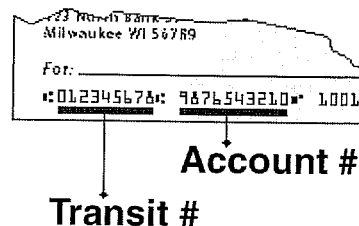
Institution Name _____

Branch / Location _____

Address _____

Check One Checking Account Savings Account

Transit Number: _____ Account Number: _____



Indicate the day of month on which you wish to have your premium payment withdrawn from your account.

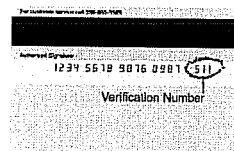
Day of month _____ (choose between the 1st and 31st of the month)

By signing below, you authorize HIRSP to instruct your financial institution to deduct your premium payments from the account designated above. You authorize your financial institution to debit the amount of your premium from your designated account. This authorization will remain in effect until your policy termination date or until you notify HIRSP in writing of its termination. Your notification must afford HIRSP and your financial institution reasonable opportunity to act on it.

Signature _____ Date Signed ____/____/____

OR

16B. **Credit / Debit Card** Select One Visa MasterCard Discover Card



Choose payment frequency: Monthly Quarterly

_____ / _____
Credit / Debit Card Number _____ Card Expiration Date _____

Name as it appears on card _____

Card Billing Address _____

Indicate the day of month on which you wish to have your premium payment charged to your account.

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

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.

Signature _____ Date Signed ____/____/____

Credit / Debit Verification Number
(This number is located on the back of your credit card. It's the three-digit number found after your card number.)

OR

16C. **Quarterly Direct Billing.** You will be sent a bill on a quarterly basis. (March, June, September, and December)

SECTION 17. 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 \$35.00 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 18. CERTIFICATION AND SIGNATURE

You certify that you are not covered under an employer-sponsored group, government, or church plan and that the foregoing statements are true to the best of your knowledge and belief. You understand that no coverage will be effective until you pay the full amount of the premium for coverage and HIRSP approves this application. You understand that you are subject to disenrollment and possible prosecution under state and federal laws if this information is false. You 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. **You agree to allow HIRSP to contact any employers listed on this application for the purpose of verifying employment and insurance information.** You understand you are responsible for all medical costs of services not covered by HIRSP. You are hereby informed of your 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 the next page 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. If you have not received the HIRSP policy or your premium payment is not returned within 6 weeks from the date shown above, notify our HIRSP Customer Service Department at the address shown above or call 800-828-4777.

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

CHECKLIST

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

Wisconsin Residency for at least three months (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.

- Documentation that you are HIV positive
- Notice of rejection of coverage from two or more insurers
- 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

Medicare (if you've completed Section 12)

- Copy of Medicare card
- Copy of Medicare Part D Prescription Drug Plan card

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 \$25,000, 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 Confidential Information Release 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. 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*	HIRSP Medicare Supplement**
Medical Deductible	\$1,000 per year	\$2,500 per year	\$5,000 per year	\$3,500 per year	\$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	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)	\$5,600 per year (includes drug coinsurance)	\$500 per year (does not include drug copay)
Drug Copay/ Coinsurance	\$10 Tier 1/ \$30 Tier 2	\$10 Tier 1/ \$30 Tier 2	\$10 Tier 1/ \$30 Tier 2	20% of allowed amount	\$10 Tier 1/ \$30 Tier 2

*HIRSP Health Savings Account (HSA)

**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 10 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 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

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

**WISCONSIN HEALTH INSURANCE RISK SHARING PLAN (HIRSP)
HIPAA PRIVACY AUTHORIZATION FOR USE OR DISCLOSURE**

The Privacy Rule standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) P.L. 104-191 require HIRSP Authority as a covered entity, to implement processes that give policyholders certain rights regarding individually identifiable health information. The information requested on this form is needed to comply with those Privacy Rule requirements.

Provision of the information that is requested on this form is voluntary. Although the use of this version of the form is voluntary, all of the information outlined on this form is mandatory.

Personally identifiable information requested on this form is mandatory in order to process your request and will only be used for this purpose.

INSTRUCTIONS: Mail this completed form to the following address:

HIRSP
P.O. Box 8961
Madison, WI 53708-8961

You are entitled to a copy of this authorization after you sign it.

SECTION I — POLICYHOLDER INFORMATION	
Name — Last, First, Middle Initial	HIRSP Identification Number
Address — Street, City, State, ZIP Code	Telephone Number ()

SECTION II — THE USE AND / OR DISCLOSURE BEING AUTHORIZED
Purpose of the use or disclosure: Describe the purpose of the requested use or disclosure. _____ _____
Health Information to be used or disclosed: Please specifically describe the health information records and the dates of the records you are authorizing be used and/or disclosed. _____ _____

Person or Organization I Authorize to Disclose Health Information: Name or specifically identify the persons or organizations, including HIRSP, who you are authorizing to disclose the health information described above. *Please include the address and telephone number for persons and/or organizations other than HIRSP.*

Name	Telephone Number ()
Address	

Name	Telephone Number ()
Address	

SECTION II — THE USE AND / OR DISCLOSURE BEING AUTHORIZED (Continued)

Person or Organization to Receive and Use: Name or specifically describe the persons or organizations, including addresses and telephone numbers, to whom you are authorizing HIRSP to disclose to or let use the health information as previously described:

Name	Telephone Number ()
Address	

Name	Telephone Number ()
Address	

I understand that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. State health record privacy regulations will still apply to my health information.

SECTION III — EXPIRATION AND REVOCATION

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

- On ___ / ___ / _____ (MM/DD/YYYY), or
- On occurrence of the following event (which must relate to the policyholder or to the purpose of the use or 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 IV — 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 persons 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.

SIGNATURE — Policyholder	Date Signed
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If this authorization is signed by a personal representative on behalf of the policyholder, provide a copy of the documentation to support the representation and complete the following:

Name — Personal Representative	Relationship to Policyholder
SIGNATURE — Personal Representative	Date Signed