

HEALTH INSURANCE PROGRAM FOR MICHIGAN APPLICATION

SECTION 1. Instructions

1. Complete the application in black or blue ink.
2. Answer all questions completely. Incomplete applications may delay the eligibility determination process.
3. Choose a Plan option
4. Sign and date the completed application.
5. Review the “check list” (section 8) at the end of this application to ensure you provided all of the required information for PHP to review and process your application.

SECTION 2. Applicant Information

Last Name	First	Middle	Gender	Telephone Number
			M <input type="checkbox"/> F <input type="checkbox"/>	() -
Street Address		City	State	ZIP Code
				Date of Birth (MM/DD/YY)
Social Security Number		Marital Status		
		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow <input type="checkbox"/> Widower		
Email Address:				

SECTION 3. Enrollment Information

Please answer “yes” or “no” to the following questions, and list any pre-existing conditions.

1. Are you resident of the State of Michigan?..... Yes No
2. Are you employed?..... Yes No
 - 2.a If so, does your employer offer coverage?..... Yes No
 - 2.b If so, are you eligible for coverage?..... Yes No
3. Are you eligible for coverage under your spouse’s employer?..... Yes No
4. If you are under the age of 26, are you eligible for insurance by a parent?..... Yes No
5. Have you been uninsured for at least 6-months?..... Yes No
6. What was the last date you had insurance coverage?..... _/ _/ _
7. Why did you lose that coverage? _____
8. Have you tried to get other coverage? Yes No
9. Are you a U.S. Citizen or national of the United States, or lawfully present in the U.S.? Yes No
10. For health reasons, has a carrier refused to issue creditable coverage within the previous 6-months?..... Yes No
11. Do you have coverage under any of the following program (s)?..... Yes No
 - Federal Medicare;
 - Michigan Medical Assistance Program;
 - Michigan Children’s Health Insurance; or
 - An employer-sponsored group health plan that includes benefits that constitutes creditable coverage.
12. Do you have any of the pre-existing condition(s) listed on the “Eligibility List of Pre-Existing Conditions” (refer to section 5)?..... Yes No

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List any pre-existing condition (s) here:

SECTION 4. Employer Information

PHP will contact any employers listed on this application for the purpose of verifying employment and insurance information.

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	
Does your employer offer health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, why are you not covered on your employer-sponsored health coverage?	
Employer Name	Employer Address/Phone number
Spouse Employer Name	Spouse Employer Address/Phone number

SECTION 5. List of Pre-Existing Conditions

The section applies to "Section- 3, question 12".

Acquired Immune Deficiency Syndrome (AIDS) Alzheimer's Angina Pectoris Anorexia Nervosa Arteriosclerosis Obliterans Artificial Heart Valve Ascites Brain Tumors Cardiomyopathy Cerebral Palsy Chronic Pancreatitis Cirrhosis of the Liver Coronary Insufficiency Coronary Occlusion Crohn's Disease Cystic Fibrosis Dermatomyositis Diabetes Epilepsy Friedreich's Disease Heart Disorders Hemophilia Hepatitis C (Active) HIV+ Hodgkin's Disease Huntington's Chorea Hydrocephalus Intermittent Claudication Kidney Failure Lead Poisoning with Cerebral Involvement Leukemia	Malignant Tumor (if treated or has occurred within last four years) Mental Retardation Metastatic Cancer Motor or Sensory Aphasia Multiple or Disseminated Sclerosis Muscular Atrophy or Dystrophy Myasthenia Gravis Myotonia Obesity – Morbid Open Heart Surgery Paraplegia or Quadriplegia Parkinson's Disease Peripheral Arteriosclerosis (if treatment within last three years) Poliomyelitis Polycystic Kidney Polyarteritis (periarteritis nodosa) Postero-lateral Sclerosis Pyschotic Disorders Rheumatoid Arthritis Sickle Cell Anemia Silicosis Splenic Anemia (True Banti's Syndrome) Still's Disease Stroke (CVA) Syringomyelia Tabes Dorsalis (locomotor ataxia) Thalassemia (Cooley's or Mediterranean Anemia) Topectomy and Lobotomy Ulcerative Colitis Wilson's Disease Lupus Erthematosus Disseminate
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SECTION 6. AGE SPECIFIC RATES and HIP PLAN OPTIONS

HIP for Michigan offers three (3) plan options which are summarized below. Your application cannot be processed if you do not choose a plan.

AGE	PLAN 1	PLAN 2	PLAN 3
Children 0-18	\$171.65	\$123.59	\$103.85
19 – 24	181.60	130.75	109.87
25 – 29	240.65	173.27	145.60
30 – 34	255.83	184.19	154.77
35 – 39	260.06	187.24	157.34
40 – 44	295.83	213.00	178.98
45 – 49	350.08	252.06	211.80
50 – 54	447.08	321.90	270.48
55 – 59	563.27	405.56	340.78
60 +	686.61	494.36	415.40
Payment Maximums:			
Annual Deductible	\$1,000.00	\$2,500.00	\$3,500.00
Annual Maximum of Deductible and Co-Insurance	\$2,500.00	\$4,000.00	\$5,000.00
Total Annual maximum for deductible, co-insurance and co pays.	\$5,950.00	\$5,950.00	\$5,950.00

Please select only one (1) HIP for Michigan plan:

- PLAN 1: (\$1,000.00 Deductible)
(Lowest deductible, highest premium)
- PLAN 2: (\$2,500.00 Deductible)
(High deductible, low premium)
- PLAN 3: (\$3,500.00 Deductible)
(Highest deductible, lowest premium)

*Note: All covered benefits are the same in each plan you choose. Only the annual payment maximums and the monthly premium payments you are responsible for vary with each plan.

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SECTION 7. Certification and Signature

I certify that the answers are true and accurate to the best of my knowledge and belief. Until PHP approves my application, and I pay the full amount of the first month's premium, I understand no coverage will be effective. I understand that I am subject to disenrollment and possible prosecution to the extent allowable under state and federal laws if this information is false, fraudulent, or contains intentional misrepresentation of a material fact. I will notify PHP in writing (P.O. Box 30377 Lansing, MI 48909) of any changes in: name, insurance, and employment status, address or telephone number. I agree to allow PHP 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 PHP Health Insurance Program. I also understand that a medical examination may be required to determine whether I am eligible for coverage.

Signature of applicant:

Date Signed:

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

NOTE: Upon receipt of your application, you will receive a confirmation letter from PHP within 10 business days from the date your application has been received. Contact PHP Customer Service at 1.877.459.3113 if you do not receive a confirmation letter within the 10 days.

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SECTION 8. Checklist

You must provide copies of the following information with your application.

Michigan Residency: all applicants

- MI Driver License

Citizenship or Lawful Presence Verification: all applicants

Citizenship:

- Birth Certificate indicating U.S. as birth nation or

Lawful Presence Verification: any one or combination of: where applicable

- I-327 (Reentry Permit)
- I-551 (Permanent Resident Card)
- I-571 (Refugee Travel Document)
- I-766 (Employment Authorized Card) accompanied by either the I-94 and an Unexpired Foreign Passport or an I-797 (Notice of Action)
- Machine Readable Immigrant Visa (with Temporary I-551 Language) affixed to Unexpired Foreign Passport
- Temporary I-551 Stamp (on passport or I-94) affixed to I-94 or Unexpired Foreign Passport
- I-94 (Arrival/Departure Record) with Unexpired Foreign Passport
- Unexpired Foreign Passport
- I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status) accompanied by I-94 and Unexpired Foreign Passport
- DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status) accompanied by I-94 and Unexpired Foreign Passport
- Other Document with an I-94 or Alien Number

Medical Condition:

- Certification by a licensed physician or nurse practitioner (within the past 6 months) that you have a history of or suffer from a medical or health condition that is listed on the "List of Pre-Existing Conditions"; or
- Notice of rejection of coverage from an insurer if you have been rejected by an insurer for any other health reason within the last 6 months.

Plan Choice:

- Check a plan you want under section 6

Mail your application, premium payment for the plan you choose and required documentation to:

PHP-HIP
P.O. Box 30377
Lansing, MI 48909-7877

If you have questions about this application, call PHP Customer Service at 1.877.459.3113.