Policy Administered by:
Blue Cross and Blue Shield of Texas[+]
P. O. Box 6089
Abilene, TX 79608-6089
Toll Free Number: 1-888-398-3927 (Administrator)

SECTION A: APPLICANT INFORMATION (please print)

An incomplete application will be delayed and the effective date of your coverage may change if all required information is not received. Use black ink only.

Last Name of Applicant			First Name of Applicant		Initial	Social Security #
Age	Date of Birth (mm/dd/yy)	Sex (check one) ☐ Male ☐ Female	Marital Status (check one) ☐ Single ☐ Married ☐ Divorced; Date _______ ☐ Widowed; Date _______			Do you use tobacco?* ☐ Yes ☐ No
Home Street Address		Apt. No.	Mailing Address (if different from Home Street Address)			
City		State	Zip Code	City	State	Zip Code
Email Address		Home/Cell Telephone #		Work Telephone #		
Name of Custodial Parent (if applicant is a minor)				Social Security #		
Name of Emergency Contact		Home/Cell Telephone #		Relationship		

SECTION B: DEPENDENTS TO BE COVERED

List qualified dependents to be covered (see definition of dependents in Outline of Coverage). A separate policy will be issued to each eligible dependent.

Last Name	First Name	Initial	Relationship to Applicant	Social Security Number	Age	Date of Birth	Sex	Do they use tobacco?*
							M F	Yes No
							M F	Yes No
							M F	Yes No
							M F	Yes No
							M F	Yes No

* Smoked cigarettes, cigars or a pipe or used chewing tobacco, nicotine chewing gum or snuff in the 12 months prior to this application.

[+] A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of Blue Cross and Blue Shield Association

SECTION C: ELIGIBILITY

1. Eligibility Information (mark all situations that apply):

☐ I am a US Citizen or a permanent legal resident of the U.S. for at least 3 continuous years. Proof of citizenship or legal residency may be required.

☐ I am a resident of the State of Texas. **Send a copy of one of the following as proof of residency: front and back of your valid driver's license or current voter registration card or current utility bill indicating your physical address. If the application is for a child under age 18, please include proof of residency for the parents. Please provide current proof of residency for dependent spouse and dependents age 18 or older, if applying for coverage.**

☐ I had health insurance coverage for at least 18 months preceding this application with no gap of coverage greater than 63 days and the most recent coverage was through an employer health plan provided by a U.S. private employer, church or governmental entity or another state's high risk pool. I have also exhausted all COBRA or state continuation coverage offered to me. **Send a copy of the Certificate of Creditable Coverage or documentation of the prior coverage. IF THIS BOX IS CHECKED, DO NOT COMPLETE SECTION 2 BELOW.**

2. Evidence of One of the Following Must Be Provided (mark one section and provide required documentation):

☐ I have received a notice of rejection or refusal to issue substantially similar individual health insurance for health reasons by an insurer. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant shall not be sufficient evidence. **Send a copy of the rejection letter from the insurance carrier.**

☒ My agent has certified that he/she is unable to obtain substantially similar individual health insurance for me with the insurance carrier he/she represents because I will be declined for coverage, as a result of my medical condition, based on the insurance carrier's underwriting guidelines. **Agent must complete Section I: AGENT INFORMATION.**

☐ I have been offered substantially similar individual health insurance coverage, but with a conditional rider excluding coverage for a medical condition. **Send a copy of the letter from the insurance carrier that includes the conditional rider exclusion. Note: COBRA and association group coverage are not considered individual coverage.**

☐ I have been diagnosed with one of the following medical or health conditions. **Send a signed and dated letter from your physician's office, stating the specific diagnosis and date of diagnosis. Please DO NOT send medical records. Check the condition(s) in the following list that applies to you:**

Cancer
- ☐ Malignant Tumor within 4 years (except skin cancer)
- ☐ Metastatic

Cardiovascular
- ☐ Artificial Heart Valve
- ☐ Cardiomyopathy
- ☐ Coronary Artery Disease
- ☐ Polyarteritis Nodosa
- ☐ Peripheral Vascular Disease, including Intermittent Claudication

Endocrine/Exocrine
- ☐ Diabetes Mellitus
- ☐ Cystic Fibrosis
- ☐ Addison's Disease

Gastrointestinal
- ☐ **Intestinal**
  - Crohn's Disease
  - Ulcerative Colitis
- ☐ **Liver**
  - Cirrhosis (non-alcoholic)
  - Wilson's Disease
  - Hepatitis

Hematopoietic
- ☐ **Anemia**
  - Sickle Cell
  - Splenic (True Banti's Syndrome)
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Thalassemia

Hodgkin's Disease
- ☐ Hodgkin's Disease

Immunological
- ☐ Acquired Immune Deficiency Syndrome (AIDS) or HIV Positive
- ☐ Lupus

Musculoskeletal
- ☐ Dermatomyositis or Polymyositis
- ☐ Muscular Atrophy or Dystrophy
- ☐ Myotonia
- ☐ Rheumatoid Arthritis
- ☐ Still's Disease
- ☐ Legge-Perthes Disease (Waldenstrom's Disease)

Neurological – Central Nervous System
- ☐ Cerebral Palsy
- ☐ Cerebral Vascular Accident (CVA)
- ☐ Epilepsy
- ☐ Huntington's Chorea
- ☐ Hydrocephalus
- ☐ Lead Poisoning with Cerebral Involvement
- ☐ Lobotomy
- ☐ Parkinson's Disease (if treatment within last 3 years)
- ☐ Guillian-Barre Syndrome

Neurological – Peripheral Nervous System (including Spinal Cord)
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Friedrich's Ataxia
- ☐ Myasthenia Gravis
- ☐ Paraplegia or Quadriplegia
- ☐ Sclerosis, Multiple, Disseminated or Postero-lateral
- ☐ Syringomyelia
- ☐ Tabes Dorsalis (Locomotor Ataxia)

Psychiatric
- ☐ Psychotic Disorders

Pulmonary
- ☐ Silicosis (Black Lung)

Renal
- ☐ Polycystic Kidney

Other
- ☐ Brain Tumor
- ☐ Down's Syndrome
- ☐ Scleroderma
- ☐ Transplants
  - Heart
  - Kidney
  - Liver
  - Lung

SECTION C: ELIGIBILITY - cont. (check all situations that apply)

Check all that apply with respect to you or any other person listed on this application (if one of these applies, you may not be eligible for coverage with the Texas Health Insurance Risk Pool):

Eligible for:

- ☐ Medicare (send a copy of your Medicare card)
- ☐ Medicaid (send a copy of your Medicaid card)
- ☐ Employer Group
- ☐ Association Group Policy
- ☐ COBRA, if offered
- ☐ State continuation
- ☐ Conversion Policy
- ☐ Other Health Insurance

Check all that apply to you or any other person listed on the application:

- ☐ Currently confined to a county jail or a state prison
- ☐ Previously received benefits from the Texas Health Insurance Risk Pool (any benefits received will reduce benefits available under a subsequent policy; $2,000,000 lifetime maximum).
- ☐ Had prior coverage with Texas Health Insurance Risk Pool that was terminated for fraud.
- ☐ Terminated or lapsed coverage with the Texas Health Insurance Risk Pool within the last 12 months.

SECTION D: EMPLOYMENT INFORMATION

Are you	☐ employed	☐ self-employed or
	☐ unemployed/retired Date_______________; if less than 18 months, provide: Last employer name:_____________________________________ Telephone:___________________________	
Is your spouse	☐ employed	☐ self-employed or
	☐ unemployed/retired Date_______________; if less than 18 months, provide: Last employer name:_____________________________________ Telephone:___________________________	

If application is made for a dependent child (under age 25 and single) employment information must also be provided for each parent and step-parent (if applicable) and the child (if applicable).

If you are employed, you must have your employer and, if you are married, your spouse's employer, complete and sign the **Employment Verification Form**. We must have the information for your spouse, even if your spouse is not applying for Pool coverage.

If you or your spouse is self-employed, you or your spouse must complete the **Self-Employment Verification Form**, for your business. We must have the information for your spouse, even if your spouse is not applying for Pool coverage.

SECTION E: OTHER INSURANCE

Supply the following information for the past 18 months for each person to be insured. **If a dependent had different coverage, provide information regarding coverage of each dependent. Attach a separate piece of paper if necessary. Please provide the Certificate of Creditable Coverage or other documentation for all health coverages in the past 12 months for credit against the preexisting condition limitation period. If you are currently on Medicare, please send a copy of your Medicare card.**

Name of policyholder		Date coverage terminated *
Name of previous health coverage carrier		Telephone number of previous carrier
Name of employer providing coverage (if any)		Telephone number of employer
Identification number of coverage		Group number (if any)
How long were you covered?	From / /	To / /
Is coverage still in force? ☐ YES ☐ NO	If **NO**, Why did coverage terminate?	

* If coverage is still in force - report "current" or scheduled termination date, if any.

SECTION F: HEALTH HISTORY

Have you or any person to be covered by the Texas Health Insurance Risk Pool received or had recommended medical advice, care or treatment, including taking prescription drugs, within the past six months? ☐ YES ☐ NO If **YES**, provide the following information. If more than one condition has been treated or family members are to be covered and additional space is needed, attach a separate piece of paper providing the requested information for each condition of each person to be covered.	
Name of Person Treated	Date of Advice/Care/Treatment
Advice, Care or Treatment Received	
Condition Treated	Treating Physician
Name of Person Treated	Date of Advice/Care/Treatment
Advice, Care or Treatment Received	
Condition Treated	Treating Physician
Name of Person Treated	Date of Advice/Care/Treatment
Advice, Care or Treatment Received	
Condition Treated	Treating Physician

SECTION G: APPLICANT'S DISCLOSURE AUTHORIZATION AND DECLARATION

I declare that no person named in this application is currently covered by a Texas Health Insurance Risk Pool policy. The foregoing statements and answers are full, complete, and true to the best of my knowledge and belief; and any coverage issued will be in full reliance upon this representation. I understand and agree that no coverage shall be effective until all requirements have been completed. I understand and agree to pay an application fee equal to the premium mode I have selected. This payment is only a deposit that will be returned if my application is denied or applied to any premium charges if my application is accepted. I understand and agree that the deposit of my application fee does not constitute acceptance of my application by the Texas Health Insurance Risk Pool.

I understand and agree that referring agents are not authorized to interpret, amend, or alter the terms of the Texas Health Insurance Risk Pool policy, nor are referring agents authorized to bind Texas Health Insurance Risk Pool in any way. I understand and agree that premiums charged for coverage and the coverage provided by the Texas Health Insurance Risk Pool are subject to change by the Board of Directors. **I understand that my coverage will not become effective until approval and acceptance of the application by Texas Health Insurance Risk Pool.**

I understand that my or my dependent's preexisting conditions, including any condition indicated on page 2 or page 4 of this application, will not be covered by the Texas Health Insurance Risk Pool policy during the preexisting condition limitation period. I further understand that if I provide proof of my or my dependent's prior creditable coverage, I or my dependent may be approved for a waiver or partial waiver of the preexisting condition limitation period. A preexisting condition is a disease or medical condition: for which the existence of symptoms would cause an ordinarily prudent person to seek diagnosis, care or treatment during the six months before an insured person's effective date of coverage; or for which medical advice, care or treatment was recommended or received during the six months before an insured person's effective date of coverage. Preexisting condition includes a preexisting pregnancy or a complication of a preexisting pregnancy, whether the complication occurs before or after the effective date of coverage. Preexisting condition does not include genetic information, in the absence of a diagnosis of the condition related to the genetic information.

I permit any physician, pharmacist, hospital or other health care provider, insurer, prepayment organization or other health plan provider to give the Texas Health Insurance Risk Pool, the Administrator or its designated representative any medical information about me or my dependents, including information about physical and mental health, medical history and drug or alcohol use. This information will be used to evaluate your eligibility for the Texas Health Insurance Risk Pool policy and claims for benefits. A reproduction of this authorization shall be as valid as the original.

The information I provide on this form and any attachments is private data under Texas law. The law does not require me to provide any data, but failure to do so will result in loss of eligibility for the Texas Health Insurance Risk Pool. By providing this data, I authorize the Texas Health Insurance Risk Pool and its Administrator to use and disclose the data as follows: any data I provide may be made available to the employees, agents, directors, officers of the Texas Health Insurance Risk Pool, the Administrator or legal counsel. It may also be made available to provider peer review panels or consultants, the actuarial or research organizations, or other persons authorized by law to receive such data.

I have read the above statement, and I agree to supply the data on this form with full knowledge of the information provided in that statement. If I am applying based on an agent's certification of my ineligibility for substantially similar coverage from an insurer or health maintenance organization, based on my medical condition(s), I hereby certify that the medical information provided on this application by the agent is correct and I agree that a copy of the agent's statement, SECTION I, may be furnished to the named insurer or HMO.

Signature of Applicant	Date (mm/dd/yy)	Signature of Custodial Parent (if applicant is under age 18)	Date (mm/dd/yy)
X		**X**	

SECTION H: PREMIUM PAYMENT METHOD

Requested Coverage Effective Date (mo./day/yr.):______________________ Please allow at least 8 business days following receipt of your complete application.
Select a Plan for each person to be covered: (A later change to a lower deductible is not allowed. Only one increase in the deductible will be allowed during a calendar year.)

PLAN I REGULAR ($1,000 Deductible) **I R**

PLAN II REGULAR ($2,500 Deductible) **II R**

PLAN III REGULAR ($5,000 Deductible) **III R**

PLAN IV REGULAR ($7,500 Deductible) (NOT AVAILABLE WITH MEDICARE) **IV R**

PLAN I MEDICARE ($1,000 Deductible) **I M**

PLAN II MEDICARE ($2,500 Deductible) **II M**

PLAN III MEDICARE ($5,000 Deductible) **III M**

PLAN V HDHP (HSA-QUALIFIED) **V HDHP**

Please Bill Me:

☐ Annually (Direct billed once a year)
☐ Semi-Annually (Direct billed twice a year)
☐ Quarterly (Direct billed every three months)
☐ Monthly Automatic Bank Deduction (Please attach a copy of a voided check, not a deposit slip, with the correct account number and fill out the authorization agreement on the next page.) T**he first month's premium payment must be submitted with the application in the form of a personal check, money order or cashier's check. Automatic Bank Deduction will begin with the second month of coverage.**

Using the table below, calculate the amount of premium due with this application. Payment should be by personal check, money order or cashier's check payable to: **Texas Health Insurance Risk Pool**. Payment of the initial premium must be submitted at the time of application, regardless of the billing method selected.

Premium Calculation Table

	Applicant's/Dependent's First Name	Age	Sex	Tobacco user?*	First 3 Digits of Zip Code	Plan Selected (insert I R, I M, II R, II M, III R, III M, IV R, or V HDHP)	Applicable premium amount from rate table**
1							
2							
3							
4							
5							
6	**Subtotal of premium rates for each person to be covered**					$	
7	**Initial premium is determined by the premium payment method selected:** Monthly = 1 month Semi-Annually = 6 months Quarterly =3 months Annually = 12 months						
8	Multiply line 6 by the number of months determined on line 7 and **INCLUDE THIS INITIAL PREMIUM AMOUNT WITH THE APPLICATION**. **TOTAL**					$	

*Smoked cigarettes, cigars or a pipe or used chewing tobacco, nicotine chewing gum or snuff in the 12 months prior to this application.

**Premium amount is calculated based on age on the policy effective date.

SECTION H (cont.): BANK DRAFT FORM

Complete this section only if you are requesting to pay premiums monthly.

Authorization Agreement for Monthly Automatic Bank Deduction of Insurance Premium

Complete and sign the Authorization Agreement for monthly Automatic Bank Deduction of Insurance Premium if you have chosen monthly payments. Please note:

- **Attach** a sample of your check marked "VOID".
- Verify your account number with your banking institution. (Frequently, the account number listed on a check includes or removes digits from the actual account number.)

As a convenience to me (or us if this is a joint account), I (we) hereby request and authorize you to pay and charge to my (our) account checks or electronic debits drawn on my (our) account by you and payable to the order of the Texas Health Insurance Risk Pool. I (we) agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me (us). This authority is to remain in effect until revoked by me (us) in writing and until you actually receive such notice. I (we) agree that you shall be fully protected in honoring any such check or electronic debit.

I (we) further agree that if any such check or electronic debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Name of Account Holder(s)			
1.			2.
Bank Name			Checking Account Number: (Do not use a savings account.)
Bank Address			
City	State	Zip Code	Routing Number:

Signature of Account Holder(s)

Name (please print)		Name (please print)	
Signature X	Date (mm/dd/yy)	Signature X	Date (mm/dd/yy)

To The Financial Institution named: In consideration of your participating in a plan which the Texas Health Insurance Risk Pool ("Company") has put into effect by which amounts due on policies of insurance are collected by checks drawn or pre-authorized electronic debits originated by the Company on the accounts of persons who are responsible for these payments, the Company does hereby agree that:

(1) It will indemnify and hold you harmless from any liability to any person arising out of the payment by you of any check or electronic debit, whether or not genuine, originated by the Company in the regular course of business for the purpose of payment, or arising out of the dishonor by you whether with or without cause, or intentionally or inadvertently, of any such check or electronic debit, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy of insurance the premium on which is sought to be collected by the Company by any such check or electronic debit; and

(2) Without limitation on the foregoing indemnities, it will refund to you any amount erroneously paid by you on any such check or electronic debit if claim for the amount of such erroneous payment is made by you within six months from the date of the check or electronic debit on which such erroneous payment was made; and

(3) Your participation in the plan or that of the depositor may be terminated by written notice from either party to the other, likewise, your participation and that of the Texas Health Insurance Risk Pool may be terminated by 30 days written notice from either party to the other.

Texas Health Insurance Risk Pool

D. Gregory Barbutti
Secretary/Treasurer
Authorized in a resolution adopted by the Board of Directors

SECTION I: AGENT INFORMATION (if applicable)

To be completed if an Insurance Agent assisted with this application.
(Information is required to process the $50 agent referral fee)

Applicant Name			Applicant Social Security #
Agent Name (Printed) DONALD KENTON HENRY, JR.			Texas Insurance License No. (Required) 651676
Business or Agency Name ALL PLAN MED QUOTE			Social Security or Tax ID # 30958
Business or Agency Address 7 SWITCHBUD PLACE, BLDG. C192, STE. 250			Work Telephone Number 800.856.6556
City THE WOODLANDS	State TX	Zip Code 77380	Fax Telephone Number 800.848.4201

I understand that Texas Insurance Code statutes, §1501.352 and §1506.159 prohibit an agent from attempting to arrange or assist in excluding an eligible individual from an employer health benefit plan, specifically by attempting to arrange or assist in obtaining coverage from the Texas Health Insurance Risk Pool. I hereby certify that, if the applicant is employed, his employer does not have employer health coverage in effect nor does the employer intend to obtain such coverage within the six months after the date of this application.

Agent's Signature	Date
X (to be applied)	(to be applied)

If Agent is certifying applicant's eligibility under Section C: ELIGIBILITY, Agent must also complete the following

Medical Condition and Approximate Date(s) of Diagnosis	Name and Address of Attending Physician
Name and address of Insurer or Health maintenance Organization that will NOT accept Applicant.	

I hereby certify that I believe I am unable to obtain individual health insurance substantially similar to the coverage offered by the Texas Health Insurance Risk Pool for this applicant from any insurer or HMO, with which I am appointed, including the indicated insurer, because the current underwriting guidelines of such insurer or HMO reflect a declination for the applicant's medical condition(s).

Agent's Signature	Date
(to be applied)	(to be applied)

The Pool reserves the right to require an attending physician's statement. A copy of this certification may be provided by the Texas Health Insurance Risk Pool to the named insurer or HMO.

TEXAS HEALTH INSURANCE POOL
EMPLOYMENT VERIFICATION FORM

Copies of this form are to be completed by you and your current employer and your spouse's current employer (even if your spouse is not covered or to be covered by the Pool). If the applicant/member is a child under the age of 25 and single, the current employer of each of the applicant/member's parents and step-parents (as applicable) must complete this form.

Individual's Information (SECTION A)	
Applicant/Member Name:	Applicant/Member Social Security Number or Unique ID
	Spouse's or Parent's Name (if applicable):
Your Signature	Date

Employer Information (To be completed and signed by current Employer only) (SECTION B)	
Employer/Business Name:	Telephone Number:
Address:	Number of Employees (including owner if employed):
Employee's Name:	
Date of Employee Hire or Business Start Date:	Waiting Period for Employer Health Coverage (if any):
How many hours a week does the employee usually work for your business?	
Do you provide group health benefit coverage, either insured or self-insured?	☐Yes ☐No
If insured, the name of the insurance company:	
Is coverage available for dependents of the employee?	☐Yes ☐No
Is the person, named above as the applicant/member, eligible for your coverage? If no, please explain:	☐Yes ☐No
Do you pay all or part of the cost of employee coverage for any employees? If yes, please explain:	☐Yes ☐No
If you pay all or part of the cost for employee coverage, is the amount paid for insurance included in the employees' taxable wages?	☐Yes ☐No
If yes, can the employee use the amount paid for any other purpose? If yes, please indicate the other permissible uses:	☐Yes ☐No
Do you pay for or reimburse or intend to pay or reimburse the person, named above as the employee, for all or part of the Pool premium, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan)?	☐Yes ☐No

Section B Continued on Other Side

If you do not currently provide coverage, was coverage provided during the last 12 months? ☐Yes ☐No

Date of and reason for coverage cancellation/termination:

If insured, the name and telephone number of insurance company:

Do you intend to provide health coverage for employees in the next 6 months? ☐Yes ☐No

Are you working with an agent or third party administrator to secure or establish group coverage? ☐Yes ☐No

If yes, the name and telephone number of the agent or the TPA:

I understand that Texas Insurance Code statutes, §1501.352 and §1506.159 prohibit an agent, a third party administrator or insurer from attempting to arrange or assist in excluding an eligible individual from an employer health benefit plan, specifically by attempting to arrange or assist in obtaining coverage from the Texas Health Insurance Pool. I hereby certify that the above answers are true and correct. I further understand that a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as the Texas Health Insurance Pool, for a person who is ineligible for such plan, is a violation of the anti-fraud provisions of the Health Insurance Portability and Accountability Act, 18 USC §1035, to which civil and criminal penalties, including imprisonment, can apply.

Employer's Signature: _________________________ Title: _______________________________

Date: ____________ Printed Name: ________________________

TEXAS HEALTH INSURANCE POOL
EMPLOYMENT VERIFICATION FORM

Copies of this form are to be completed by you and your current employer and your spouse's current employer (even if your spouse is not covered or to be covered by the Pool). If the applicant/member is a child under the age of 25 and single, the current employer of each of the applicant/member's parents and step-parents (as applicable) must complete this form.

Individual's Information (SECTION A)	
Applicant/Member Name:	Applicant/Member Social Security Number or Unique ID
	Spouse's or Parent's Name (if applicable):
Your Signature	Date

Employer Information (To be completed and signed by current Employer only) (SECTION B)	
Employer/Business Name:	Telephone Number:
Address:	Number of Employees (including owner if employed):
Employee's Name:	
Date of Employee Hire or Business Start Date:	Waiting Period for Employer Health Coverage (if any):
How many hours a week does the employee usually work for your business?	

Do you provide group health benefit coverage, either insured or self-insured? ☐Yes ☐No

If insured, the name of the insurance company:

Is coverage available for dependents of the employee? ☐Yes ☐No

Is the person, named above as the applicant/member, eligible for your coverage? ☐Yes ☐No
If no, please explain:

Do you pay all or part of the cost of employee coverage for any employees? ☐Yes ☐No
If yes, please explain:

If you pay all or part of the cost for employee coverage, is the amount paid for insurance included in the employees' taxable wages? ☐Yes ☐No

If yes, can the employee use the amount paid for any other purpose? ☐Yes ☐No
If yes, please indicate the other permissible uses:

Do you pay for or reimburse or intend to pay or reimburse the person, named above as the employee, for all or part of the Pool premium, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan)? ☐Yes ☐No

Section B Continued on Other Side

If you do not currently provide coverage, was coverage provided during the last 12 months? Date of and reason for coverage cancellation/termination: If insured, the name and telephone number of insurance company:	☐Yes ☐No
Do you intend to provide health coverage for employees in the next 6 months? Are you working with an agent or third party administrator to secure or establish group coverage? If yes, the name and telephone number of the agent or the TPA:	☐Yes ☐No ☐Yes ☐No

I understand that Texas Insurance Code statutes, §1501.352 and §1506.159 prohibit an agent, a third party administrator or insurer from attempting to arrange or assist in excluding an eligible individual from an employer health benefit plan, specifically by attempting to arrange or assist in obtaining coverage from the Texas Health Insurance Pool. I hereby certify that the above answers are true and correct. I further understand that a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as the Texas Health Insurance Pool, for a person who is ineligible for such plan, is a violation of the anti-fraud provisions of the Health Insurance Portability and Accountability Act, 18 USC §1035, to which civil and criminal penalties, including imprisonment, can apply.

Employer's Signature: _________________________ Title: _______________________________

Date: ____________ Printed Name: ________________________

TEXAS HEALTH INSURANCE POOL
SELF-EMPLOYMENT VERIFICATION FORM

Individual's Information (SECTION A)

Applicant/Member Name:	Applicant/Member Social Security Number or Unique ID
	Spouse's Name (if any):

Employment Information for: ☐Self ☐Spouse ☐Mother ☐Father ☐Other ___________________

Business Information (SECTION B)

Employer/Business Name:	Telephone Number:
Address:	
How long have you been self-employed?	How many hours a week do you usually work?

Do you have any full time employees (work 30 hours per week or more)? ☐Yes ☐No

If so, how many?

Do you provide group health benefit coverage, either insured or self-insured? ☐Yes ☐No

If insured, the name of the insurance company: ____

Do you pay all or part of the cost of employee coverage for any employees other than yourself? ☐Yes ☐No
If yes, please explain:

If you pay all or part of the cost for employee coverage, is the amount paid for insurance included in the employees' taxable wages? ☐Yes ☐No

If yes, can the employee use the amount paid for any other purpose? ☐Yes ☐No
If yes, please indicate other permissible uses:

Does the employer pay for or reimburse or intend to pay or reimburse the person, named above as the employee, for all or part of the Pool premium, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan)? ☐Yes ☐No

Do you intend to provide health coverage for employees in the next 6 months? ☐Yes ☐No

Are you working with an agent or third party administrator to secure or establish group coverage? ☐Yes ☐No
If yes, the name and telephone number of the agent or the TPA:

I understand that Texas Insurance Code statutes, §1501.352 and §1506.159 prohibit an agent, a third party administrator or insurer from attempting to arrange or assist in excluding an eligible individual from an employer health benefit plan, specifically by attempting to arrange or assist in obtaining coverage from the Texas Health Insurance Pool. I hereby certify that the above answers are true and correct. I further understand that a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as the Texas Health Insurance Pool, for a person who is ineligible for such plan, is a violation of the anti-fraud provisions of the Health Insurance Portability and Accountability Act, 18 USC §1035, to which civil and criminal penalties, including imprisonment, can apply.

Employer's Signature: _________________________ Title: _______________________________

Date: _____________ Printed Name: _______________________

Another copy of this form is provided on the other side.
Both sides are only required if more than one person is self-employed.

TEXAS HEALTH INSURANCE POOL
SELF-EMPLOYMENT VERIFICATION FORM

Individual's Information (SECTION A)

Applicant/Member Name:	Applicant/Member Social Security Number or Unique ID
	Spouse's Name (if any):

Employment Information for: ☐Self ☐Spouse ☐Mother ☐Father ☐Other ___________________

Business Information (SECTION B)

Employer/Business Name:	Telephone Number:
Address:	
How long have you been self-employed?	How many hours a week do you usually work?

Do you have any full time employees (work 30 hours per week or more)? ☐Yes ☐No

If so, how many?

Do you provide group health benefit coverage, either insured or self-insured? ☐Yes ☐No

If insured, the name of the insurance company: ____

Do you pay all or part of the cost of employee coverage for any employees other than yourself? ☐Yes ☐No

If yes, please explain:

If you pay all or part of the cost for employee coverage, is the amount paid for insurance included in the employees' taxable wages? ☐Yes ☐No

If yes, can the employee use the amount paid for any other purpose? ☐Yes ☐No

If yes, please indicate other permissible uses:

Does the employer pay for or reimburse or intend to pay or reimburse the person, named above as the employee, for all or part of the Pool premium, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan)? ☐Yes ☐No

Do you intend to provide health coverage for employees in the next 6 months? ☐Yes ☐No

Are you working with an agent or third party administrator to secure or establish group coverage? ☐Yes ☐No

If yes, the name and telephone number of the agent or the TPA:

I understand that Texas Insurance Code statutes, §1501.352 and §1506.159 prohibit an agent, a third party administrator or insurer from attempting to arrange or assist in excluding an eligible individual from an employer health benefit plan, specifically by attempting to arrange or assist in obtaining coverage from the Texas Health Insurance Pool. I hereby certify that the above answers are true and correct. I further understand that a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as the Texas Health Insurance Pool, for a person who is ineligible for such plan, is a violation of the anti-fraud provisions of the Health Insurance Portability and Accountability Act, 18 USC §1035, to which civil and criminal penalties, including imprisonment, can apply.

Employer's Signature: _________________________ Title: _______________________________

Date: _____________ Printed Name: _______________________

Another copy of this form is provided on the other side.
Both sides are only required if more than one person is self-employed.

CHECKLIST FOR APPLICATION

Must Be Completed and Returned with Application

BEFORE MAILING YOUR APPLICATION, PLEASE COMPLETE THIS CHECKLIST, WHICH MUST BE SUBMITTED WITH YOUR APPLICATION.

1. Application SECTION C: ELIGIBILITY INFORMATION

a. I have included proof of Texas residency, indicating physical address, by providing **one** of the items below for each person, age 18 or over, to be covered :

___ A copy of the front and back of a valid Driver's License.
or ___ A copy of a valid Voter Registration Card.
or ___ A copy of a current Utility Bill

If application is for a child under age 18, please include proof of Texas residency for parent(s).

b. I have selected and included proof of **one** of the following:

___ I have maintained health insurance coverage for the past 18 months or more, with no gap in coverage greater than 63 days and the last coverage through an employer sponsored plan of a U.S. private employer, church or government entity, or another state's high risk pool. I have enclosed a termination letter* and a copy of my previous ID card, showing when coverage began, or a Certificate of Creditable Coverage from my previous insurance carrier or, if a self-funded plan, from my employer.
or ___ I have enclosed a letter of notice of rejection* from one insurer for substantially similar individual health insurance coverage due to medical reasons.
or _X_ My agent has completed the agent certification, Section I on the application indicating that I am unable to obtain substantially similar individual health insurance, as a result of a medical condition, based on the insurance carrier's underwriting guidelines. The insurance company name and address are included.
or ___ I have enclosed a copy of a letter* offering substantially similar individual health coverage by an insurer with a conditional rider excluding coverage for medical reasons (COBRA and association group coverage are not individual coverage).
or ___ I have enclosed a letter from my physician's office, indicating that I have been diagnosed with one of the Pool's qualifying medical conditions, listed on the application, including the date of diagnosis.

2. Application SECTION D: APPLICANT/SPOUSE EMPLOYMENT

___ I have included the completed Employment Information form(s), if required.

3. Application SECTION E: OTHER INSURANCE (for Preexisting Condition Waiting Period Credit)

___ I have enclosed a termination letter* and a copy of my previous ID card, showing when coverage began, or a Certificate of Creditable Coverage from my previous insurance carrier or, if a self-funded plan, from my employer. NOTE: This documentation is not required to complete the application process; if you do not submit it with your application, however, your claims could be denied during the preexisting condition waiting period.

4. Application SECTION H: PREMIUM PAYMENT METHOD

a. ____ I have selected a Deductible Plan.

b. ____ I have INCLUDED a personal check, money order or cashier's check for the initial premium payment (see Section H of the application for the required premium amount; checks must be payable to the Texas Health Insurance Risk Pool).

c. For **all applicants paying monthly:**

____ I have completed page 7 of the application.
____ I have included a voided check.

***Note:** The document must be written on insurance company letterhead with the applicant's name included.