



Administered by BMI P.O. Box 1090 Great Bend, Kansas 67530 Toll-Free number 1-877-888-6447

## APPLICATION FOR COVERAGE

APPLICANT IDENTIFICATION		
Social Security Number	Name (Last, First, Middle Initial)	
Date of Birth (Month, Day, Year)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Mailing Address
Length of time at present address:		(City, State, Zip Code + 4, County)
Telephone Number: (    )		
PLAN ELECTION		
Please Choose One Plan: <input type="checkbox"/> <b>Indemnity Option A</b> (\$1,750 Deductible) <input type="checkbox"/> <b>Indemnity Option B</b> (\$3,500 Deductible) <input type="checkbox"/> <b>Managed Care Option A</b> (\$1,000 In-Network Deductible and \$2,000 Out-of-Network Deductible) <input type="checkbox"/> <b>Managed Care Option B</b> (\$2,500 In-Network Deductible and \$3,500 Out-of-Network Deductible) <input type="checkbox"/> <b>Managed Care Option C</b> (\$5,000 In-Network Deductible and \$7,500 Out-of-Network Deductible) <input type="checkbox"/> <b>Managed Care Option D</b> (\$10,000 In-Network Deductible and \$12,500 Out-of-Network Deductible) <input type="checkbox"/> <b>Managed Care Option H</b> (\$5,250 In-Network Deductible and \$7,750 Out-of-Network Deductible)		<b>Maternity Benefits Rider</b> (Available For Option A plans only)  Please answer "yes" or "no" to include the optional maternity rider:  <input type="checkbox"/> Yes <input type="checkbox"/> No  If Yes, add in the monthly maternity rider premium to the monthly plan premium.
<b>Non-Tobacco User Discount:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, you must complete the Non-Tobacco User Affidavit		

**Policy Effective Date** – If accepted for this coverage, your effective date may be no earlier than the first of the month following the date we receive your complete application and required premium.

Premium Payment     Monthly Bill – Administrative fee will be added.

Method:     Monthly Bank Debit – Send check for first month's premium with application and complete the following:

<b>DEBIT AUTHORIZATION</b> – I authorize New Hampshire Health Plan (NHHP) to initiate debit entries (charges) to my account indicated below and the Financial Institution named below to charge the said account.		
Financial Institution	Town/City	Account Number (Checking)
This authority is to remain in full force and effect until the Financial Institution has received written notification from me of its termination in such time as to afford the Financial Institution a reasonable opportunity to act on it. The initial authorization is for \$_____ to be charged to my account on the first of each month. Such amount may be changed from time to time by NHHP in accordance with the terms of the policy. <input type="checkbox"/> <b>Attach a voided check for our records.</b>		

**ELIGIBILITY CERTIFICATION:** I certify that I am eligible for this coverage as follows (Please check whichever applies to you):

1.  I am a NH resident, and have been rejected for other health insurance coverage. **(Please attach a copy of the rejection notice.)** or;
2.  I am a NH resident, and have or have been offered health insurance coverage substantially similar to this program, but at higher rates. **(Please attach a copy of the insurance offer showing higher rates.)** or;
3.  I am a NH resident and am eligible for the coverage because of my health condition of: \_\_\_\_\_ **(Please attach proof of having or being diagnosed with such condition.)** or;
4.  I am a NH resident, and 1) have an aggregate of at least 18 months prior creditable coverage, most recently under an employee group health plan, governmental plan or church plan; 2) am not eligible for another group health plan, Medicare or Medicaid; 3) do not have other health insurance; and 4) am not eligible for, have not been offered, or have exhausted continuation coverage under COBRA or similar program. **(Please attach employer letter, prior carrier letter or other proof.)** or;
5.  I am a NH resident, and either a resident dependent of the following person or a resident family member of the following child who is covered by NH Health Plan: \_\_\_\_\_ **(Please identify person.)** or;
6.  I am a NH resident, and I have been certified as eligible for either  federal trade act assistance or  pension benefit guaranty corporation assistance. **(Please attach proof.)** or;
7.  I am a NH resident, and have been offered health insurance coverage with a rider or endorsement excluding coverage for a specified condition. **(Please attach a copy of the insurance offer showing the exclusion.)**

- A. Are you covered by or eligible for Medicare, Medicaid or Title XXI (NH Healthy Kids)?  Yes  No
- B. Do you have other health insurance coverage that you do not intend to terminate?  Yes  No  
If Yes, state name of company \_\_\_\_\_
- C. Are you eligible for health coverage through your employer or the employer of your spouse or parent?  Yes  No

**Please Note: If the answer is "Yes" to any of the above questions A-C, you are not eligible. No benefits are payable under this policy for any period under which a policy with a prior effective date remains in force.**

Other Coverage Information

During the past two years, have you been covered under another health plan (Major Medical, Major Hospital or HMO) with another company? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details below:					
Name	Company Name	Policy/Certificate #	Issue Date	Paid-To Date	Type of Coverage:
					<input type="checkbox"/> Major Med <input type="checkbox"/> Major Hosp <input type="checkbox"/> HMO List Deductible, Maximum Amount, Benefits, etc.

**Please Note:** The policy applied for will not pay benefits for the treatment of certain preexisting conditions. Refer to the Preexisting Condition Limitation provision of the policy. In determining whether a preexisting condition limitation applies, we will credit the time you were previously covered under Creditable Coverage if the Creditable Coverage was continuous (with no break in coverage over 62 days) to a date not more than 63 days prior to receipt of the application. **To get credit toward satisfaction of the preexisting condition period, you must submit certificate(s) or other evidence of all prior Creditable Coverage.**

I have received the appropriate Outline of Coverage.

I represent that my answers and statements on this application are true and complete to the best of my knowledge. I understand that if they are not, my policy may not be valid and I may be subject to prosecution for insurance fraud. I understand that all hospitalizations and certain other procedures as specified in my policy must be precertified or benefits will be reduced. I authorize providers of health care to furnish the Administrator with medical information to the extent necessary for processing this application or claims.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Premium payments will be required on a monthly basis due on the first of each month.**

A check made payable to NHHP for the first monthly premium is submitted with this application.

A New Hampshire Health Plan Residency Affidavit is submitted with this application.

If you consulted an Agent or Broker regarding this coverage, please have the Agent or Broker complete this section.

**AGENT/BROKER USE ONLY** (Please Print) Under penalties of perjury, I declare that I am aware of no information contrary to the answers and statements on this application and the New Hampshire Health Plan Residency Affidavit submitted herewith.

Printed Name Richard E Allen Telephone Number 603 625 2266

(Optional) Pay My Commission To \_\_\_\_\_

Street Address 1340 Rodwell RD City Manchester State NH Zip + 4 03109

Signature Richard E Allen Date \_\_\_\_\_ Tax ID or SS# \_\_\_\_\_

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**OFFICIAL USE ONLY**

Group No. \_\_\_\_\_ Dept. No. \_\_\_\_\_ Effective Date \_\_\_\_\_

Approved \_\_\_\_\_ Date \_\_\_\_\_ Rejected \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT NOTICE:** Any person who supplies false information in this application or in any application, claim or other matter with respect to the New Hampshire Health Plan (or who assists or encourages any other person to do so), may be subject to prosecution for insurance fraud. Penalties may include fines, license suspension or revocation, and imprisonment.



**Residency Affidavit**

1. Under penalty of perjury, I declare that I am a resident of the State of New Hampshire as defined in paragraph (3) below. I understand that if I falsely claim to be a resident of the State of New Hampshire, I am subject to prosecution, imprisonment of up to one year, a fine of up to \$2,000 and the denial of any claim under the insurance policy for which I am applying.
2. I also understand that this statement will be relied upon in connection with future renewals of the insurance policy for which I am applying and the payment of claims, and that it is my responsibility to inform the New Hampshire Health Plan when I cease to be a New Hampshire resident and that I will be subject to the penalties listed above if I fail to do so.
3. A resident is a person who maintains his or her true, fixed and permanent residence within the State of New Hampshire, does not claim a residence in any other state for any purpose and who has, through all of his or her actions, demonstrated a current intent to designate that the permanent residence is his or her principal place of physical presence for the indefinite future to the exclusion of all others.
4. The permanent residence referred to above is located at

\_\_\_\_\_ *street address (not P.O. Box)*  
\_\_\_\_\_, New Hampshire \_\_\_\_\_  
*city or town* *zip*

5. I understand that I may be asked to file an updated affidavit with New Hampshire Health Plan from time to time and other confirmatory proof of residence (e.g., rent receipts, mortgage payments, and utility bills). I will cooperate when asked to do so.

I, the applicant, have read the above and understand the penalties that may apply if I falsely claim to be a New Hampshire resident.

Date: \_\_\_\_\_ Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_

**For applicants under the age of 18:** I am the  custodial parent /  legal guardian of the applicant. Under penalties of perjury, I declare that the above statements of or on behalf of the applicant are true.

Date: \_\_\_\_\_ Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_

My residence is: \_\_\_\_\_  
*street address (not P.O. Box)*  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
*city or town* *state* *zip*

My telephone: home: \_\_\_\_\_ work: \_\_\_\_\_  
*area code & number* *area code & number*



**Non-Tobacco User Affidavit**

Under penalty of perjury, I declare that I neither (i) presently smoke or use tobacco products, nor (ii) have smoked or used tobacco products at any time during the 12 months immediately preceding the date of this affidavit. I understand that if I falsely claim the non-tobacco user discount on my application for insurance, I am subject to prosecution, imprisonment of up to one year, a fine of up to \$2,000, an obligation to pay the additional premium required of tobacco users and the denial of any claim under the insurance policy for which I am applying.

“Smoke or use tobacco products” for purposes of this affidavit means any use of cigarettes, pipes, cigars or any other tobacco products regardless of the number of times, frequency or method of use.

I, the applicant, have read the above and understand the penalties that may apply if my statements are false.

Date: \_\_\_\_\_ Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_

**For applicants under the age of 18:** I am the  custodial parent /  legal guardian of the applicant. Under penalties of perjury, I declare that the above statements of or on behalf of the applicant are true.

Date: \_\_\_\_\_ Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_