

HOW TO APPLY

Complete the enclosed OHRP Application for Coverage and submit it with the first month's premium. Applicants applying on the basis of MEDICAL ELIGIBILITY and those applying on the basis of FEDERALLY DEFINED ELIGIBILITY must attach different documentation.

MEDICAL ELIGIBILITY Documentation

You must provide one of the following to document 12-months residency in Oklahoma:

- recent Oklahoma tax returns, or
- 12-month old Oklahoma driver's license showing current Oklahoma address; or
- 12-month old utility bill showing current Oklahoma address.

If you have been diagnosed with one of the conditions identified on the current conditions list in this brochure provide a letter from your physician.

If you have been rejected for health care coverage by at least two insurance carriers, include a letter or form from the authorized representatives of two Oklahoma-licensed health insurers or health plans documenting the underwriting action taken. This documentation must indicate that the coverage was refused.

If you are being charged substantially more than the OHRP Plan's rates for an individual plan health care coverage, include the premium bill from your insurer.

If you have been accepted for health insurance coverage but are subject to a permanent exclusion or waiver of a pre-existing condition or disease, include the policy form that indicates the exclusion of coverage for specific conditions.

FEDERALLY DEFINED ELIGIBILITY Documentation

A certificate of creditable coverage, or other proof of creditable coverage, from all previous insurers the aggregate of which is 18 months. Evidence of election of COBRA and the exhaustion of COBRA, if COBRA was available to you, or other State Continuation program.

If applicant's most recent coverage within the period of aggregate creditable coverage was terminated for reasons other than non-payment of premiums or fraud, attach a certificate of canceled coverage indicating the termination reason and termination date.

Note: Your first month's premium must be submitted with your application. Checks should be made payable to Oklahoma High Risk Pool.

Notification of Acceptance or Denial of Coverage: If your OHRP Application for Coverage meets all program requirements, the OHRP Administrator will notify you of your acceptance or denial. A benefit booklet and identification card will be issued to each applicant who is accepted.

Effective Dates and Premium Payments: Eligible applicants who are accepted for OHRP will be notified of their effective date of coverage. Premiums may be paid by direct bill or automatic withdrawal. You must notify the Administrator, complete and return the proper forms to set up automatic withdrawal.

You may apply through an Oklahoma licensed insurance agent, but an agent is not required to apply. You may apply directly to the OHRP plan Administrator.

MAIL THE APPLICATION TO:

OHRP
PO Box 1090
Great Bend, KS 67530

FOR MORE INFORMATION CALL:

1-877-793-6477

CURRENT MEDICAL CONDITIONS LIST

One of several requirements for Medical Eligibility is having been rejected by two companies for similar coverage. If an applicant currently has one of the conditions listed below, he/she may submit, in lieu of the two rejection requirement, a letter from a physician verifying the applicant has the condition.

Cancer- Bone, Brain, Breast, Colon, Liver, Lung

Cardiovascular- Artificial Heart Valve, Cardiomyopathy, Coronary Atherosclerotic Disease which was symptomatic with MI, Polyarteritis Nodosa

Endocrine/Exocrine- Cystic Fibrosis, Diabetes Mellitus

Gastrointestinal Intestinal- Crohn's Disease, Ulcerative Colitis

Hematopoietic- Aplastic Anemia, Hemophilia, Hodgkin's Disease, Leukemia, Sickle Cell Disease

Immunological-ADA (Adenosine deaminase deficiency), AIDS or HIV positive, Ataxia – Telangiectasia, SCID (Severe-combined immunodeficiency disease), Scleroderma, Systemic lupus erythematosus, Wegener's granulomatosis, X-linked agammaglobulinemia

Liver-Cirrhosis (non-alcoholic), Hepatitis C, Wilson's Disease

Musculoskeletal-Dermatomyositis or polymyositis Muscular dystrophy

Neurological / Central Nervous System - Alzheimer's Disease, Cerebral Palsy, Cerebrovascular Accident (CVA), Developmental disability (mental retardation), Encephalitis (active or resulting impairment), Hydrocephalus, Lobotomy (accidental or surgically induced), Parkinson's disease (if treatment in past 3 years), Seizure disorder (symptomatic in past 3 years)

Neurological / Peripheral Nervous System (including spinal cord)- Amyotrophic Lateral Sclerosis (ALS), Paraplegia or Quadriplegia, Sclerosis, Multiple, Disseminated or Postero-Lateral Syringomyelia (spina bifida)

Pulmonary- Asthma (steroid dependent), Bronchopulmonary dysplasia, Chronic Obstructive Pulmonary insufficiency, oxygen dependent, Pulmonary Fibrosis with pulmonary insufficiency

Renal-Chronic renal failure, with or without dialysis, Polycystic kidney

If you have questions after reading all information provided, please contact:

OHRP
PO Box 1090
Great Bend, KS 67530
1-877-793-6477

OKLAHOMA HEALTH INSURANCE HIGH RISK POOL ORIGINAL POLICY APPLICATION

Please print all information.

1. Applicant information

Requested Effective Date: _____

A.	Name: Last	First	Middle	I	<input type="checkbox"/>	Male		Date of Birth M/D/Y	
					<input type="checkbox"/>	Female			
	Address: Number	Street	City		State	ZIP		County	
	Telephone Number						Social Security No.		
B.	Person whom OHRP may contact in an emergency: Name: Last First Middle							Relationship to you	
	Address: Number	Street	City		State	ZIP	Telephone No.	()	
C.	Name and address of your employer, if any:							Employer's telephone number ()	
D.	Are you now totally disabled? Yes ___ No ___ If "Yes", please describe your disability. _____								

2. Spouse / Dependents Desiring Coverage

	IDENTIFY RELATIONSHIP	NAME (First, M.L, Last if Different from Applicant)	Social Security Number	BIRTH DATE (Mo-Day-Yr)
M F	SPOUSE			
M F	DEPENDENT 1			
M F	DEPENDENT 2			
M F	DEPENDENT 3			
M F	DEPENDENT 4			

3. OHRP Deductible Selection. Please select the deductible amount you want. Note: Your Spouse and Dependents, if **covered**, will each have the same deductible you select. Each one must satisfy their individual deductibles in each Calendar Year (subject to the family deductible provisions in the Schedule of Benefits).

\$500
 \$1,000
 \$1,500
 \$2,000
 \$5,000
 \$7,500

4. Current Health Care Coverage Information

- | | |
|--|----------------|
| A. Are you employed? | Yes ___ No ___ |
| Is your spouse employed? | Yes ___ No ___ |
| B. Are you covered by group insurance through your employer? | Yes ___ No ___ |
| Are you covered by group insurance through your spouse's employer? | Yes ___ No ___ |
| C. Are you currently enrolled in, or eligible for, Medicare or Medicaid? | Yes ___ No ___ |
| D. Have you previously had company sponsored coverage terminated? | Yes ___ No ___ |
| E. Do you have health insurance presently in force? | Yes ___ No ___ |

If the insurance to be issued is intended to replace any other accident and health insurance and/or you answered "Yes" to any question, please complete sections F and G below. Attach an extra sheet if necessary. If you answered "No", go on the next section.

F. Name of Primary Person Covered Name of Insurance Co. Is this coverage provided by:
Your Employer? Spouse Employer?
_____ _____ Yes ___ No ___ Yes ___ No ___

G. Have you had continuous coverage under another policy with respect to the given pre-existing condition up to the date of this application? Yes ___ No ___

If you answered "Yes", please complete all information below. If "No", go on to section 6.
Name, Address and Phone Number Period of Coverage Policy Number
of Insurance Company
_____ _____ _____

Are you eligible for or currently covered under COBRA? _____ (if yes give dates of coverage) _____

6. Eligibility

I am eligible for coverage with OHRP for the following reasons:

_____ I am applying for OHRP because of **MEDICAL ELIGIBILITY** please sign AFFIRMATION FORM #1

_____ I am applying for OHRP coverage because I no longer have or am about to lose group health insurance, COBRA or other coverage and am not eligible for Medicare or Medicaid and I satisfy the definition of a **FEDERALLY DEFINED ELIGIBLE** individual. Please sign AFFIRMATION FORM #2. We will need proof of such prior coverage to establish sufficient aggregate creditable coverage. Acceptable forms of proof are; certificate of creditable coverage, policy or other insurer letters, pay stubs, billing statements, canceled checks, insurance cards, EOB's, Cobra election letter, payroll deduction documents, records from health providers, phone calls or statements from third parties, or any other document that evidences periods of health coverage.

X _____ **Date:** _____

Applicant's Signature if 15 or older
(Parent's or Legal Guardian's Signature for children under 15)

It is not required that you have an insurance agent involved in this application process for OHRP, so you can leave blank the agent's statement below. However, if an agent assists in the process, please ask the agent to complete the following statement.

Agent's Statement: I have a valid agent's or broker's license in the state of Oklahoma for accident and health insurance. I have assisted the applicant in completing this application for coverage with OHRP. To the best of my knowledge and belief the information contained in the application and this affirmation form is correct and complete. I certify that the applicant meets the OHRP eligibility standards.

Print Agent's Name Tax ID No. Agency Phone Number

Agent's Signature Address City/State Zip

**OKLAHOMA HEALTH INSURANCE HIGH RISK POOL
HEALTH STATEMENT**

Your health status does not disqualify you for the OHRP program. However, your answers to these questions are important to the operation of the program.

Each of the following questions must be answered "Yes" or "No". In addition, each condition which caused you to answer "Yes" must be circled, and described on the next page.

Your policy will not cover expenses incurred during the first 12 months after its Effective Date of Coverage for a pre-existing condition. A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment (including prescriptions) was recommended or received within the six month period ending on the enrollment date. This provision does not apply to federally qualified individuals.

During the past two years, have you had or been advised of, positively diagnosed with, or treated for any of the following conditions?

- | | |
|--|----------------|
| 1. Anemia, other blood disease or disorder | Yes ___ No ___ |
| 2. Arthritis, lupus, gout or any inflammation, recurrent pain or diminished range of motion in the joints, including knees or hips (please indicate the specific problem on the following page) | Yes ___ No ___ |
| 3. Back, neck or spinal column disorders, including back adjustments recurrent back pain or immobility | Yes ___ No ___ |
| 4. Bladder infections, kidney infections, kidney stones, or any other bladder, kidney or urinary disorder | Yes ___ No ___ |
| 5. Breast disorder, fibrocystic disease, breast implant or reduction | Yes ___ No ___ |
| 6. Cancer, cysts, tumors, polyps, or other growths | Yes ___ No ___ |
| 7. Congenital disease or birth defect | Yes ___ No ___ |
| 8. Diabetes, goiter or thyroid disorder or disorder of the glands | Yes ___ No ___ |
| 9. Acquired Immune Deficiency Disorder (AIDS) or related complex (ARC) | Yes ___ No ___ |
| 10. Eating disorder, such as anorexia or bulimia | Yes ___ No ___ |
| 11. Emphysema, bronchitis or any chest, lung or respiratory problem or disorder | Yes ___ No ___ |
| 12. Epilepsy, seizures, migraine or recurrent headaches | Yes ___ No ___ |
| 13. Fractures, dislocations, polio, loss of limb(s), bone disorders (On the following page, please indicate the involved limb(s) [left or right, arm or leg] and if screws, pins or plates are now in place. | Yes ___ No ___ |
| 14. Gallstones, gallbladder disorder; hernia (except hiatal) | Yes ___ No ___ |
| 15. Sexually-transmitted diseases, such as genital herpes, syphilis, gonorrhea, chlamydia or venereal warts | Yes ___ No ___ |
| 16. Heart murmur, irregular heartbeat, rheumatic fever, chest pain, heart valve problem, heart attack or any other heart condition | Yes ___ No ___ |
| 17. Hepatitis, cirrhosis or any other liver disorder | Yes ___ No ___ |
| 18. Disorder of the male or female reproductive organs, including enlarged prostate, prostatitis, menstrual irregularity or disorder, fibroid uterus, abnormal pap smear or ovarian cyst | Yes ___ No ___ |
| 19. Pregnancy | Yes ___ No ___ |
| 20. Muscular or neurological disorder, such as muscular dystrophy, multiple sclerosis, cerebral palsy or Parkinson's | Yes ___ No ___ |
| 21. Nervous, mental or emotional condition; attempted suicide, depression or mental retardation | Yes ___ No ___ |
| 22. Paralysis, stroke, TIA or high blood pressure | Yes ___ No ___ |
| 23. Ulcers, colitis, hemorrhoids, ulcerative colitis, Crohn's, hiatal hernia or any other stomach, intestine, bowel or rectal disorder | Yes ___ No ___ |
| 24. Varicose veins, clots, poor circulation or any other vein/artery disorder | Yes ___ No ___ |

During the past two years, have you:

25. Had an operation or been hospitalized? Yes ___ No ___
26. Been treated or counseled for alcoholism, the use of alcohol, drug abuse or the use of drugs? Yes ___ No ___
27. Had any other condition, disorder, ailment or injury not listed above for which you have had or plan to seek advice, diagnosis or treatment? Yes ___ No ___
28. Consulted a doctor, chiropractor, therapist or other health care provider? Yes ___ No ___
29. If you answered "Yes" to any of the questions number 1-28, complete this section. Give complete details, including the number of each item that you answered "Yes". Attach an additional sheet of paper if necessary.

Item No.	Dates of illness or Conditions or Symptoms	Diagnosis, Treatment, Medication or Reason for Visit	Is further treatment needed?	Were you hospitalized?	Name and Address of Doctor and/or Hospital
	From _____ To _____		-Yes No	-Yes No	
	From _____ To _____		-Yes No	-Yes No	
	From _____ To _____		-Yes No	-Yes No	
	From _____ To _____		-Yes No	-Yes No	

30. Have you taken prescribed medications within the last year? Yes ___ No ___
If "Yes", please describe below.

Medicine	Dosage	Reason	Name/ Address of Prescribing Doctor

31. Your Current primary physician:

Name: _____ Specialty: _____
 Address: _____ Telephone: _____
 City, State, Zip: _____

32. Has future surgery, diagnostic testing or medicinal treatment been recommended or discussed for you? Yes ___ No ___
 If "Yes", complete the following section.

Date _____ Diagnosis _____

Type of operation or treatment? _____

X _____

Date: _____

Signature of Applicant or Parent or Legal Guardian
 Note: If the applicant is under 15 years of age, a parent or legal guardian must sign above to indicate consent.

**AFFIRMATION FORM #1
MEDICAL ELIGIBILITY**

Please read carefully and sign below.

I hereby apply for OHRP coverage, as offered by the Oklahoma Health Insurance High Risk Pool. I understand and agree to everything listed below:

I certify that all the information I provided on this application is true and complete.

I will pay monthly the premiums billed by OHRP for the benefits that I requested.

If my premiums are not paid within 31 days after the due date, my coverage will end as of the date payment was due.

Any hospital, doctor or other provider of health care services is hereby authorized to release all necessary medical information about my care.

I understand that if I am eligible for OHRP because of medical eligibility, benefits will not be payable during the first 12 months after coverage is effective, for any condition for which medical advice, diagnosis, care or treatment (including prescription medication) was recommended or received during the six month period immediately preceding the effective date of coverage.

I certify that I have been a resident of Oklahoma for at least twelve months prior to making this application.

Proof of my residency (copy of driver's license and/or Oklahoma tax return and/or utility bill) is attached to this application.

I am eligible for coverage with OHRP for the following reasons (please check each that apply):

I have applied for health insurance and been rejected by two carriers because of health conditions;

I have applied for health insurance and been quoted a rate for coverage substantially more than the Pool's rate; or

I have been accepted for health insurance subject to a permanent exclusion or waiver of a pre-existing disease or condition.

I have a listed condition.

I understand that my OHRP Contract can be canceled if I provide any false or incomplete information on this application. Then I must repay any benefits that I was not entitled to receive. I understand that this is an application only. I will be notified in writing if I am accepted into the OHRP Program. I understand that I must initial and date any changes I make while I am completing this application.

I will be responsible for obtaining Pre-admission Authorization prior to any non-emergency admission to a hospital or alcoholism treatment facility, and within 72 hours after an emergency admission.

I will let OHRP know if and when I am no longer eligible for OHRP coverage, such as, because I change residence, become eligible for Medicare, or begin receiving Medicaid benefits. Failure to do so will result in repayment of any and all benefits provided to the insured which were paid after the insured failed to meet eligibility requirements.

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to me or any of my dependents, which may have a bearing on the benefits payable by this or any other Plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge. A photocopy of this authorization shall be valid as the original.

X _____
Applicant's Signature if 15 or older (Parent or Legal
Guardian's Signature for children under 15)

Date _____

Signature of Witness _____

Date _____

**AFFIRMATION FORM #2
FEDERALLY DEFINED ELIGIBILITY**

Please read carefully and sign below.

I hereby apply for OHRP coverage, as offered by the Oklahoma Health Insurance High Risk Pool. I understand and agree to everything listed below:

I certify that all the information I provided on this application is true and complete.

I will pay monthly the premiums billed by OHRP for the benefits that I requested.

If my premiums are not paid within 31 days after the due date, my coverage will end as of the date payment was due.

Any hospital, doctor or other provider of health care services is hereby authorized to release all necessary medical information about my care.

I understand that my OHRP Contract can be canceled if I provide any false or incomplete information on this application. Then I must repay any benefits that I was not entitled to receive.

I understand that this is an application only. I will be notified in writing if I am accepted into the OHRP Program.

I understand that I must initial and date any changes I make while I am completing this application.

I will be responsible for obtaining Pre-admission Authorization prior to any non-emergency admission to a hospital or alcoholism treatment facility, and within 72 hours after an emergency admission.

I will let OHRP know if and when I am no longer eligible for OHRP coverage, such as, because I change residence, become eligible for Medicare, or begin receiving Medicaid benefits.

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to me or any of my dependents, which may have a bearing on the benefits payable by this or any other Plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge. A photocopy of this authorization shall be valid as the original.

X _____

Applicant's Signature if 15 or older (parent or Legal
Guardian's Signature for children under 15)

Date _____

Signature of Witness _____

Date _____



PO Box 1090
Great Bend, KS 67530
1-877-793-6477
620-793-1199 fax

www.okhrp.org

Administered by Benefit Management, Inc.

Tobacco Use Affidavit

This form is used to determine your premium rate. Beginning January 1, 2010, you are only eligible for the lower non-tobacco user rate after you certify that you have been tobacco-free during the prior 12 months.

Name _____

Member ID#: _____

TOBACCO USE INFORMATION

Check the applicable box below:

➤ I have used tobacco products during the prior 12 months. Yes No

NOTE: Tobacco products include cigarettes, cigars, chewing or pipe tobacco or any other tobacco products regardless of the frequency or method of use.

By signing this form, I certify the following:

1. I have truthfully checked the Yes or No box above that accurately reflects my use of tobacco products in the prior 12 months.
2. I understand that tobacco products include cigarettes, cigars, chewing or pipe tobacco or any other tobacco products regardless of the frequency or method of use.
3. I understand that if I currently use tobacco products and stop using tobacco products in the future, I will be eligible for the lower non-tobacco user rate the month following OHRP's receipt of a new Tobacco Use Affidavit certifying that I have not used tobacco products during the prior 12 months.
4. I understand that if I fail to complete this Affidavit truthfully, OHRP may adjust my premium charges retroactively for the applicable higher tobacco-user rate. Upon written notification, I must reimburse OHRP any amounts reduced from my premiums for the period for which I falsely certified eligibility for the non-tobacco user rate.
5. I understand that if I state on this form that I do not use tobacco products, I may be asked at a later date to supply a certification from my physician that I am not a tobacco user.

X

Signature

Date Signed