SCHIP

South Carolina Health Insurance Pool
P. O. Box 61173 • Columbia, SC 29260

SOUTH CAROLINA HEALTH INSURANCE POOL APPLICATION

Phone: In Columbia Area: 803-264-6401
Outside Columbia Area: 800-868-2500, Ext. 46401

☐ New Application ☐ Change Request

PART I: APPLICATION INFORMATION (Please print or type. Complete both front and back of this application.

Coverage (Select One) ☐ SCHIP Network 80/60 Option - $500 Deductible
☐ SCHIP Network 80/80 Option - $500 Deductible
☐ SCHIP High Deductible Health Plan Option - $1,500 Deductible

Name _____ ☐ Male ☐ Female
Last First Middle

Mailing Address: _____ Apt. No.: _____

City: _____ State: _____ Zip: _____ Business Phone: _____ Home Phone: _____

Social Security Number _____ - _____ - _____ Birthdate ____ / ____ / ____ Age: _____ yrs.

PART II: COMPLETE ONLY IF APPLICANT IS UNDER AGE 18 OR LEGALLY INCAPACITATED

The Responsible Party applying for this coverage is the applicant's: ☐ Parent ☐ Grandparent ☐ Legal Guardian (papers attached)

Full Name of the Responsible Party: _____

Street Address (No P.O. Box or RR): _____ Apt. No.: _____

City: _____ State: _____ Zip: _____ Business Phone: _____ Home Phone: _____

PART III: OTHER INSURANCE INFORMATION

1. Have you been covered previously under SCHIP? ☐ Yes ☐ No
   Reason for termination: _____
2. Are you eligible for or enrolled in Medicare? ☐ Yes ☐ No
   Identification Number: _____ Part A Effective Date: _____ Part B Effective Date: _____
3. Has the applicant ever had health insurance coverage in the past? ☐ Yes ☐ No
4. What type of coverage was this?
   a. ☐ A group plan?
      1. When did your coverage begin? _____ end? _____
      2. Why did your coverage end? _____
      3. Have you exhausted your continuation of coverage? ☐ Yes ☐ No
      4. What is the name of the prior insurance company? _____
      5. What was your policy or identification number? _____
   b. ☐ Individual policy?
      When did your last coverage end and why? _____
5. Is this coverage to replace it? ☐ Yes ☐ No If "no," please explain: _____

FOR USE OF SCHIP

Effective Date	Accept	Reject	Waiver
____ / ____ / ____			

PART IV: PREMIUM BILLED MONTHLY (Refer to Premium Rate Table for Amount Due.)

Method of Payment: ☐ Monthly Bank Number: _____

☐ Bank Draft (Complete Authorization Agreement) Account Number: _____

PART V: ELIGIBILITY REQUIREMENTS (Refer to SCHIP Outline of Coverage for detailed information.)

A. Residency: Applicant and responsible party (if applicable) must be a resident of South Carolina. "Resident" means any person who has resided continuously in a place of permanent habitation within the State of South Carolina for at least 30 days immediately preceding this application for health insurance. This requirement is waived for a Federally Defined Eligible Individual or a Qualified TAA Eligible Individual. However, proof of residency will be required within 30 days after acceptance. (See SCHIP Outline of Coverage for required attachments.)

Applicant has been a South Carolina resident continuously since ____ / ____ / ____.

Responsible party (if applicable) has been a South Carolina resident continuously since ____ / ____ / ____.

B. Received any of the following notifications from an insurer on an application for health insurance:

☐ 1. Refusal to issue the insurance for health reasons.

☐ 2. Refusal to issue the insurance without reducing or excluding coverage for a pre-existing condition for a period longer than twelve months.

☐ 3. Refusal to issue the insurance except at a rate greater than 150% of the SCHIP monthly rate.

☐ 4. Paying a current single monthly premium amount for the insurance that is or will be increasing to a rate greater than 150% of the SCHIP monthly rate.

A copy of the notice on the Insurance Company's letterhead must accompany the application.

C. Are you any of the following:

☐ Yes ☐ No Eligible for a Trade Readjustment Allowance (TRA) under the Trade Adjustment Assistance (TAA) program?

☐ Yes ☐ No Receiving benefits under the Alternative Trade Adjustment Assistance (ATAA) program?

☐ Yes ☐ No Receiving a pension benefit from the Pension Benefit Guaranty Corporation (PBGC)?

If you answered "Yes" to any of these questions, please include a copy of the Authorization Form that you received from the US Department of Health and Human Services (HHS).

PART VI: PRE-EXISTING INJURY OR SICKNESS

State the primary health condition(s) that prevent(s) you from obtaining standard coverage:

_____

READ CAREFULLY BEFORE SIGNING: I represent that the foregoing statements are true and accurate to the best of my knowledge and belief. I understand that this application will not be processed until the Administrator receives this application, required proof(s) of eligibility and the full initial premium. I certify that in the event I obtain other comparable health insurance or change my residency from the State of South Carolina, I will provide written notification of the coverage and/or my new address to the Administrator.

I hereby authorize the release of all past and future medical records needed to process this application or claims to the Administrator, or its representative. I also authorize release of Medicare Part A and B claims information needed to process claims. A photocopy of this authorization shall be as valid as the original.

I acknowledge receipt of a SCHIP Outline of Coverage, which was provided to me with the application.

I understand that if I am accepted, this coverage may be terminated if the Administrator finds that I misled the Administrator about any other coverage I have or the risk it is assuming on this application. I also understand that no healthcare provider, health entity, public or private institution, or any other person or entity which does not have an insurable interest may be responsible for any premium, deductible or coinsurance for this policy unless I am a TAA Eligible Individual (see Part V section C above).

_____	_____	_____	_____
Signature of Applicant	Date Signed	Signature of Responsible Party (if applicable)	Date Signed