NATIONAL FINANCE CENTER

U. S. DEPARTMENT OF AGRICULTURE

Instructions for Completing Your Application for the Pre-Existing Condition Insurance Plan

The Pre-Existing Condition Insurance Plan provides a new health coverage option to people who have been uninsured for at least six months, have a pre-existing condition or have been denied health coverage because of their health condition, and are a U.S. citizen or are residing in the U.S. legally. For a monthly premium, the Pre-Existing Condition Insurance Plan covers a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. The Plan doesn't charge you a higher premium because of your medical condition.

To apply, you may complete an online application at **www.pcip.gov**. Or, you can complete a paper application, which is available at **www.pcip.gov**, or by calling **1-866-717-5826** (TTY **1-866-561-1604**).

1. When filling out this application, print clearly in blue or black ink.
2. You must answer every question on this application and include copies of any documents that we require you to send us with your application. We cannot process your application unless it is complete. If you are helping someone fill out this application, remember to answer the questions about the person applying for coverage.
3. Please remember to print your full name on the line located at the top of pages 2, 3, and 4.
4. You must sign and date your application on page 4.
5. Review the Checklist for Submitting Your Application on page 5 to make sure that your application is complete.
6. The Official Processing Center for the Pre-Existing Condition Insurance Plan is in New Orleans, Louisiana. Mail your application and all required documents to:

   National Finance Center
   Pre-Existing Condition Insurance Plan
   P.O. Box 60017
   New Orleans, LA 70160-0017

7. If you are eligible, we will mail you a letter that includes the amount of your monthly premium and instructions for making your first premium payment to complete your enrollment. Do not send any payment with this application.
8. If you are eligible, you will pay a monthly premium for a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. Premiums vary by state and age. In 2010, for example, someone who is 50 years old will pay a monthly premium that ranges from $330 per month to $556 per month depending on the state where the person lives.
9. If you are eligible, you will have access to preventive care (paid at 100%, with no deductible) when you see an in-network doctor and your doctor indicates a preventive diagnosis. For all other care, in 2010 you will pay a $2,500 in-network/$3,000 out-of-network deductible. More information about the benefit is available at **www.pciplan.com**.
10. For help completing this application or if you have any questions, please call **1-866-717-5826** (TTY **1-866-561-1604**), or visit **www.pcip.gov**.

Form Approved
OMB No. 0938-1095

APPLICATION FOR THE PRE-EXISTING CONDITION INSURANCE PLAN

Section 1: Information about the Person Applying for Coverage.

Last Name	First Name	Middle Initial	Maiden Name (if applicable)	Age	Date of Birth (mm/dd/yyyy)

Social Security Number (if you have one)	Gender	Telephone Number with Area Code	Email Address (if you have one)
	☐ Male ☐ Female		

Permanent Address

City	State	Zip Code

Mailing Address (only if your Mailing Address is different from your Permanent Address)

City	State	Zip Code

Section 2: Information about the State Where You Live.

To be eligible for this coverage, you must live in a state that is served by the Pre-Existing Condition Insurance Plan.

What state do you live in? _____

Section 3: Information about Your Citizenship or Immigration Status.

Please check one of the following boxes:

☐ **I am a citizen of the United States.**
You must provide your Social Security Number in Section 1 because you are attesting that you are a U.S. citizen. We will match your information, including your Social Security Number, with information in Federal records.

☐ **I am a noncitizen national of the United States.**
You must provide a copy of a document that confirms your status as a noncitizen national, such as a copy of a U.S. passport that shows your national status.

☐ **I am a noncitizen who is lawfully present in the United States.**
You must provide a copy of your immigration document, including a document that has your Alien Registration Number or I-94 Number, to verify your current immigration status. A list of acceptable documents is on page 5 of this form.

★ **NAME**

Section 4: Information about Your Medical Condition or Diagnosis.

Please check the box that applies to you:

☐ Because I have a medical condition, I received either a denial letter from an insurance company for individual insurance coverage (not health insurance offered through a job) in my state that is dated within the past 6 months, or I received a letter dated within the past 6 months from an insurance agent or broker licensed in my state that tells me that I am not eligible for individual insurance coverage from one or more insurance companies because of my medical condition. (You must provide a copy of the insurance company's denial letter or a copy of the agent or broker's letter.)

☐ I received an offer of individual insurance coverage (not health insurance offered through a job) from an insurance company in my state that is dated within the past 6 months. This offer of coverage has a rider that says my medical condition won't be covered. (You must provide a copy of your offer of coverage with the rider that shows that your medical condition won't be covered. Please note that if you currently have insurance coverage that doesn't cover your medical condition, you are not eligible for the Pre-Existing Condition Insurance Plan.)

☐ **(APPLICABLE ONLY FOR A CHILD UNDER AGE 19 OR FOR A PERSON WHO LIVES IN MASSACHUSETTS OR VERMONT)** I have a medical condition, and I received an offer of coverage from a health insurance company for individual insurance (not health insurance offered through a job) in my state that is dated within the past 6 months. This letter shows a premium for this coverage that is at least twice as much as the Pre-Existing Condition Insurance Plan premium (the monthly payment you make to an insurer to get and keep insurance) for my state. (You must provide a copy of the insurance company's letter showing the premium for the individual coverage you were offered. To find out if the premium you were offered is twice as much as the premium in the Pre-Existing Condition Insurance Plan, visit **www.pcip.gov**.)

Section 5: Information about Your Other Coverage.

To be eligible for this coverage, you must have been without other health coverage for at least 6 months from the date of this application. At any point in the past 6 months, have you had any of the following types of coverage? You must answer each question.

Yes	No	
☐	☐	Individual or job-based health plan, including COBRA?
☐	☐	Medicare (Part A and/or Part B)?
☐	☐	Medicaid?
☐	☐	Children's Health Insurance Program (or CHIP)?
☐	☐	A state high risk pool?
☐	☐	TRICARE (military health insurance)?
☐	☐	Health coverage provided by a public health plan established by a state, the U.S. government such as coverage provided to veterans enrolled in VA health care, or a foreign country?
☐	☐	FEHBP (health insurance for Federal employees or retirees), including Temporary Continuation of Coverage (TCC)?
☐	☐	Health benefit plan provided to Peace Corps workers?
☐	☐	Services provided by the Indian Health Service or by a Tribe or Tribal organization for treating your medical condition?

★ **NAME**

We also want to know about any health coverage you had in the past 12 months. If you had health coverage from more than <u>two</u> insurance companies or providers in the past 12 months, you only need to identify the <u>two</u> most recent ones. If you did not have coverage, you can leave this section blank.

Name of Insurance Company or Program that Provided Your Health Coverage:

Insurance Company Address:	Insurance Company Telephone Number with Area Code:	
City:	State:	Zip Code:
Employer Name (if coverage was provided by the employer):	Coverage Start Date:	Coverage End Date:

Reason Your Health Coverage Ended (Check All That Apply):

- ☐ Because you or someone in your family lost or left their job.
- ☐ Because your insurance company stopped covering dependents.
- ☐ Because you or someone in your family stopped working full-time and were no longer eligible for benefits.
- ☐ Because you moved out of the insurance company's service area.
- ☐ Other. State the reason your coverage ended: _____

Information for any other health coverage in the past 12 months.

Name of Insurance Company or Program that Provided Your Health Coverage:

Insurance Company Address:	Insurance Company Telephone Number with Area Code:	
City:	State:	Zip Code:
Employer Name (if coverage was provided by the employer):	Coverage Start Date:	Coverage End Date:

Reason Your Health Coverage Ended (Check All That Apply):

- ☐ Because you or someone in your family lost or left their job.
- ☐ Because your insurance company stopped covering dependents.
- ☐ Because you or someone in your family stopped working full-time and were no longer eligible for benefits.
- ☐ Because you moved out of the insurance company's service area.
- ☐ Other. State the reason your coverage ended: _____

★ **NAME**

Section 6: Verifying Your Understanding of this Application and Signing It.

1. I understand that my coverage will not begin until (a) this completed application and all required documents are received and approved, and (b) I am billed for the first month's premium and my payment is received and processed.
2. I understand that it is my responsibility to inform the Pre-Existing Condition Insurance Plan of any health insurance coverage that I may get in the future.
3. I understand that, if I move out of the area served by that the Pre-Existing Condition Insurance Plan, I must notify the Plan so that I can disenroll.
4. I understand that if I voluntarily disenroll from the Pre-Existing Condition Insurance Plan or if I am disenrolled involuntarily (for example, for failure to pay my premium on time), I may not re-apply for enrollment until at least 6 months after my coverage ends.
5. I understand and agree to the release of the information on this application to the United States Department of Agriculture's National Finance Center, other Federal agencies, and Federal contractors to determine my eligibility and enroll me in the Pre-Existing Condition Insurance Plan.
6. I understand that, by signing below, I certify that all information and documents provided as part of this application for coverage are complete, accurate, and true to the best of my knowledge. I understand that, if this application has intentional material misstatements or omissions, the Pre-Existing Condition Insurance Plan may, during the first 2 years of my enrollment, (a) cancel my enrollment as though it were never effective and refund my premiums, less any claims that were paid on my behalf, and/or (b) take any other action available by law.

Signature	Today's Date

If you are a parent or legal guardian or an authorized representative of the person applying for coverage, you must sign above and provide the following information:

Full Name	Telephone Number with Area Code

Mailing Address

City	State	Zip Code

Check Your Relationship to the Person Applying for Coverage:

- ☐ Parent
- ☐ Legal Guardian
- ☐ Authorized Representative

Section 7: Checklist for Submitting Your Application.

- ☐ I have completed this entire application and have answered every question.
- ☐ I have signed and dated this application.
- ☐ I have included with this application a copy of a letter from an insurance company denying coverage or excluding coverage for my medical condition. Or, if applicable, I have included a copy of a letter from an insurance company showing the premium quote I was offered for coverage.
- ☐ **(U.S. Citizens Only)** I have provided my Social Security Number.
- ☐ **(U.S. Noncitizen Nationals Only)** I have included a copy of a document that confirms my status as a noncitizen national, such as a copy of a U.S. passport that shows my national status.
- ☐ **(Noncitizens Only)** I have included a copy of my immigration documents, including at least one that has my Alien Registration Number or I-94 Number that will be used to verify my status. I have provided a copy of:
  - ☐ I-327 (Reentry Permit)
  - ☐ I-551 (Permanent Resident Card)
  - ☐ I-571 (Refugee Travel Document)
  - ☐ I-766 (Employment Authorization Document)
  - ☐ 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 for Visa Waiver Program travelers
  - ☐ I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status) accompanied by I-94 and an Unexpired Foreign Passport
  - ☐ DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status) accompanied by I-94 and an Unexpired Foreign Passport
  - ☐ Other Document with an I-94 or Alien Number

PRIVACY ACT AND PAPERWORK REDUCTION NOTICE

Section 1101 of the Patient Protection and Affordable Care Act, Public Law 111-148, authorizes the collection of information on this form. The information you provide will allow the United States Department of Health and Human Services through the United States Department of Agriculture's National Finance Center to determine if you are eligible for the Pre-Existing Condition Insurance Plan. We are required to ask for your Social Security Number if you attest that you are a U.S. citizen. We match your information, including your Social Security Number, against Federal records, such as those maintained by the Social Security Administration. We perform this match by computer to confirm your information and verify whether you are eligible for the Pre-Existing Condition Insurance Plan. Only individuals who are citizens or nationals of the United States or are otherwise lawfully present in the United States are eligible for this program. If you do not provide this information, we will not be able to make a decision on your application.

Paperwork Reduction Act Statement. This information collection meets the requirements of 44 United States Code §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. The valid OMB control number for this information collection is 0938-1095. We estimate that it will take about 1 hour to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **Send only comments relating to our time estimate to this address, not your application form.**