Application for Health Care Coverage
For assistance with completing your application, call us at 1-800-543-7105 weekdays 8:30 a.m. until 4:30 p.m. (TTY - Dial 711)

If you would like a copy of this application in Spanish, please call us at 1-800-543-7105 weekdays 8:30 a.m. until 4:30 p.m. (TTY - Dial 711)

Si desea una copia de esta solicitud en Español llámenos al 1-800-543-7105 weekdays 8:30 a.m. until 4:30 p.m. Los usuarios de equipo teleescriptor (TTY - Marcar 711)

ENGLISH - You can get this information interpreted for you or translated into another language. This service is free. Call 1-800-543-7105.

SPANISH - Usted puede solicitar que se le interprete esta información o que se le traduzca a otro idioma. Este servicio es gratuito. Llame al 1-800-543-7105.

VIETNAMESE - Quý vị có thể được thông tin này thông dịch cho quý vị hoặc phiên dịch sang ngôn ngữ khác. Dịch vụ này là miễn phí. Xin gọi số 1-800-543-7105.

RUSSIAN – Эту информацию для Вас могут перевести устно или письменно на другой язык. Эта услуга бесплатная. Позвоните по телефону 1-800-543-7105.

ITALIAN - Può richiedere spiegazioni o traduzioni in un’altra lingua per meglio comprendere tali informazioni. Il servizio è gratuito. Telefonate al 1-800-543-7105.

CHINESE (MANDARIN-SIMPLIFIED) – 您可以要求有人将该信息为您口译，或者要求将该信息翻译成另一种语言。此为免费服务。请电 1-800-543-7105。

CAMBODIAN - អំណាច់អំពីអត្ថបទប្រកបដោយ អាចរកគេដើម្បីជួយរៀនឬសន្និសីទយុវនេះ ដ៏សមស្រស់ ឬព្រះបាទសុខភាព អំពីរៀនឬទូទៅ 1-800-543-7105 ។
Information About Health Care Coverage

Who can use this application?
You can use this application to apply for anyone in your family. You can still apply even if you don’t file a federal income tax return.

What programs are available?
1) Children’s Health Insurance Program (CHIP):
   - Free CHIP: Provides free health insurance for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance.
   - Low-Cost CHIP: Provides low-cost health insurance for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance. Families must pay a monthly premium for each child and there are copayments for certain services.

2) Medical Assistance:
Provides free health insurance for children, teens, and adults who qualify.

3) Health Insurance Marketplace:
Provides access to private health insurance plans that offer comprehensive coverage. In addition, you may be eligible for a new tax credit that would help pay your health insurance premiums. Visit www.healthcare.gov to learn more.

Apply faster online.
Apply online at www.compass.state.pa.us.

Enrollment in these programs is based on tax household size and adjusted household income. This application will work for all of the above programs. All information you provide on this form is confidential and may be shared between the programs as necessary. The age of your child(ren) as well as your adjusted household income will determine which program is right for your family.

- If your child is not eligible for CHIP, this application will be sent to the County Assistance Office to see if either you or your child is eligible for Medical Assistance or the Health Insurance Marketplace.
- You will get a letter from us within 30 days telling you what has happened to the application and what to expect.
How to Apply

1. Read the application carefully and complete all information. PLEASE PRINT. An application that is not complete will slow down the process for enrollment in health care coverage, if the applicant is eligible.

2. If you need help completing any part of this application, please contact us at 1-800-986-KIDS (CHIP).

3. Attach copies of proof of all household gross income (before taxes and deductions) that reasonably represents your household's current income. If possible, all income documents should be dated within 60 days of the date you apply. Proof of household income is listed below:
   - One pay stub from the last 60 days for each person working in the household. Send more pay stubs if pay changes regularly. If you do not get pay stubs, submit a signed and dated letter from the employer on company letterhead which states the hourly rate, number of hours (regular and overtime) worked per pay, frequency of pay and gross pay. Bonus and commission information should be provided, as well. The employer’s phone number and address should be included, in case we have any questions.
   - If a household member is self employed: include the most recent federal income tax return and all related tax schedules or submit a year-to-date profit and loss statement showing the business name, time frame being reported, gross income received, only business related expenses by line item, and the net profit. Please sign and date.
   - If a household member is a seasonal or temporary employee: indicate the number of months worked during the year and if Unemployment Compensation is received when not working.
   - If Unemployment Compensation is received by a household member: submit the Notice of Financial Determination award letter or check stubs.
   - If retirement, pension, or Worker’s Compensation is received: submit the most recent award letter or Form 1099.
   - If court ordered alimony is received: submit the court order or a copy of the payment history for the past 12 months from the Department of Welfare’s PA Child Support Enforcement System at www.childsupport.state.pa.us.

4. If you are applying for someone who is not a U.S. Citizen, you must provide proof of their legal status by presenting documentation from the U.S. Citizenship and Immigration Service.

5. Attach copies of proof of tax deductions.

6. When you have completed the application and gathered copies of all necessary supporting documentation, please sign and date the application and return it to the insurance company in your county listed on pages 14 and 15 using the postage-paid envelope included.

CHIP benefits:
- Doctor office visits
- Prescription drugs
- Dental
- Eye care and eyeglasses
- Diagnostic tests
- Durable medical equipment
- Emergency care
- Hearing care
- Home health care
- Hospitalization
- Immunizations
- Laboratory tests/x-rays
- Mental health services/substance abuse
- Pregnancy

Who to include when applying:

Include:
- Yourself
- Your spouse or unmarried partner
- Anyone under 21 who lives with you
- Anyone you include on your tax return, even if they don’t live with you.

Si desea una copia de esta solicitud en Español llámenos al 1-800-986-KIDS (CHIP).
CHIP benefits:
- Doctor office visits
- Prescription drugs
- Dental
- Eye care and eyeglasses
- Diagnostic tests
- Durable medical equipment
- Emergency care
- Hearing care
- Home health care
- Hospitalization
- Immunizations
- Laboratory tests/x-rays
- Mental health services/substance abuse
- Pregnancy
- Emergency care
- Hearing care
- Home health care
- Hospitalization
- Immunizations
- Laboratory tests/x-rays
- Mental health services/substance abuse
- Pregnancy

Who to include when applying:
Include:
- Yourself
- Your spouse or unmarried partner
- Anyone under 21 who lives with you
- Anyone you include on your tax return, even if they don’t live with you.

Si desea una copia de esta solicitud en Español llámenos al 1-800-986-KIDS (CHIP).

Important information about health care benefits.
Please have someone read this to you.

Важная информация относительно пособий на медицинское обслуживание. Пожалуйста, проигнорите кого-нибудь, прочитать его вам.

Thông tin quan trọng về quyền lợi chăm sóc sức khỏe. Xin nhờ người khác đọc thông tin này cho quý vị.

Read the application carefully and complete all information. PLEASE PRINT. An application that is not complete will slow down the process for enrollment in health care coverage, if the applicant is eligible.

If you need help completing any part of this application, please contact us at 1-800-986-KIDS (CHIP).

If you are applying for someone who is not a U.S. Citizen, you must provide proof of their legal status by presenting documentation from the U.S. Citizenship and Immigration Service.

Attach copies of proof of tax deductions.

When you have completed the application and gathered copies of all necessary supporting documentation, please sign and date the application and return it to the insurance company in your county listed on pages 14 and 15 using the postage-paid envelope included.
Tell us who you are and where you live (person completing this application).

IMPORTANT: All persons applying must provide or apply for a Social Security Number (SSN), if eligible for one, and answer citizenship questions. Providing an SSN is optional for persons not applying for health care coverage, but providing it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health care coverage costs. If someone wants help getting an SSN, call 1-800-777-1213 or visit socialsecurity.gov (TTY users call 1-800-325-0778).

What is your primary language?  
☐ English  ☐ Spanish  ☐ Other (specify): ________________________________

Last Name (Parent/Guardian/Head of Household): ___________________________  
First Name: ___________________________  
Middle Initial: ___________________________  
Suffix: ___________________________

Home Street Address (Include street, apt. number, city, state and zip (+4 digit)):  
County: ___________________________

Mailing Address (If different than home address):  
☐ Check if you don’t have home address. You must still provide a mailing address.

Primary Phone Number:  
Phone Type:  
☐ Home  ☐ Work  ☐ Cell

Secondary Phone Number:  
Phone Type:  
☐ Home  ☐ Work  ☐ Cell

How do you prefer that we communicate with you in the future?  
☐ Mail  ☐ E-mail

E-mail Address: ___________________________

Please tell us about your family (continued).

Is anyone applying not a U.S. Citizen?  
☐ Yes  ☐ No

If yes, fill in the following information.

Name of Person Who Is Not a U.S. Citizen: ___________________________

Eligible immigration status?  
☐ Yes  ☐ No

INS Document Type (I-551I, I-94, etc.): ___________________________

Document ID # (Alien #, etc.): ___________________________

Lived in the U.S. since 1996?  
☐ Yes  ☐ No

Is this person a veteran or in active duty in the U.S. Military?  
☐ Yes  ☐ No

Tell us who you are and where you live (person completing this application).  
See page 2 for a list of who to include.

Is anyone who lives with you a parent, stepparent or adoptive parent to any children listed in this application?  
☐ Yes  ☐ No

If yes, please explain: ___________________________

Please tell us about your family (Start with yourself). See page 2 for a list of who to include.

This chart is a continuation from the chart on previous page (page 4).
Tell us who you are and where you live (person completing this application).

IMPORTANT: All persons applying must provide or apply for a Social Security Number (SSN), if eligible for one, and answer citizenship questions. Providing an SSN is optional for persons not applying for health care coverage, but providing it can speed up the application process. We use SSNs to check income and other information to see who is eligible for help with health care coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov (TTY users call 1-800-325-0778).

What is your primary language?  □ English □ Spanish □ Other (specify): __________________________

Last Name (Parent/Guardian/Head of Household): __________________________
First Name: __________________________
Middle Initial: ______
Suffix: __________________________

Home Street Address (Include street, apt. number, city, state, county and zip (+4 digit): __________________________

Mailing Address (If different than home address): __________________________

Primary Phone Number: __________________________  Phone Type: ______
  □ Home □ Work □ Cell
Secondary Phone Number: __________________________  Phone Type: ______
  □ Home □ Work □ Cell

How do you prefer that we communicate with you in the future?  □ Mail □ E-mail

Please tell us about your family (Start with yourself). See page 2 for a list of who to include.

If anyone who lives with you is a parent, stepparent or adoptive parent to any children listed in this application?  □ Yes □ No

If yes, please explain: __________________________

Please tell us about your family (continued).

Is anyone applying not a U.S. Citizen?  □ Yes □ No

If yes, fill in the following information.

Name of Person Who Is Not a U.S. Citizen  __________________________
Eligible immigration status?  □ Yes □ No □ Yes □ No

INS Document Type (SS1, IM4, etc.)  __________________________
Document ID # (Alien #, etc.)  __________________________
Lived in the U.S. since 1996?  □ Yes □ No □ Yes □ No

Is this person a veteran or in active duty in the U.S. Military?  □ Yes □ No □ Yes □ No

Is anyone applying not a U.S. Citizen?  □ Yes □ No

If yes, fill in the following information.

Name of Person Who Is Not a U.S. Citizen  __________________________
Eligible immigration status?  □ Yes □ No □ Yes □ No

INS Document Type (SS1, IM4, etc.)  __________________________
Document ID # (Alien #, etc.)  __________________________
Lived in the U.S. since 1996?  □ Yes □ No □ Yes □ No

Is this person a veteran or in active duty in the U.S. Military?  □ Yes □ No □ Yes □ No

Is anyone who lives with you a parent, stepparent or adoptive parent to any children listed in this application?  □ Yes □ No

If yes, please explain: __________________________

This chart is a continuation from the chart on previous page (page 4).

Please list below:

Last Name, First Name, M.I., Suffix

Are you applying for this person?  □ Yes □ No

Sex:  □ M □ F

Is this person:
  □ Married
  □ Single
  □ Divorced
  □ Separated
  □ Widowed

Birth Date MM/DD/YYYY

Social Security Number (See "Important" note above)

Yourself

Person #2

Person #3

Person #4

Person #5

Person #6

Is anyone who lives with you a parent, stepparent or adoptive parent to any children listed in this application?  □ Yes □ No

If yes, please explain: __________________________

Please complete Appendix B.

† Please complete Appendix B.

If you need more space please attach a separate sheet of paper.

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### 3a. Tax Filing Status

Complete this information for your spouse/partner and children who live with you and/or anyone else on your same federal income tax return if you file one. See page 2 for more information on who to include.

Do any of the persons listed on the application plan to file a federal income tax return NEXT YEAR?  □ Yes  □ No

If yes, list each tax filer, and list the spouse of the tax filer if filing a joint tax return.

<table>
<thead>
<tr>
<th>Name of Tax Filer</th>
<th>If Filing Jointly – Name of Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Will any of the persons listed on the application claim any dependents on their tax return?  □ Yes  □ No

If yes, list tax filer and list dependents.

A dependent can be claimed by only one tax filer. For joint filers, you need to list dependents for the tax filer who will sign the tax form.

<table>
<thead>
<tr>
<th>Name of Tax Filer</th>
<th>Name and Date of Birth of Dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You don't need to complete the information in the table below if the dependent is already listed above.

Will any of the persons listed on the application be claimed as a dependent on someone else's tax return?  □ Yes  □ No

If yes, list dependent, and list tax filer for whom the dependent will be claimed.

<table>
<thead>
<tr>
<th>Name of Dependent</th>
<th>Name and Date of Birth of Tax Filer</th>
<th>Relationship to Tax Filer</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
3b. Income:

Income includes, but is not limited to:
- Wages, salaries, tips, bonuses, commissions, etc.
- Interest
- Dividends
- Taxable refunds, credits, or offsets of state and local income taxes
- Alimony received
- Self-employment net profit/loss
- Capital/other gain/loss
- IRA distributions
- Pensions and annuities
- Rental real estate, royalties, trusts and REMIC
- Farm income/loss
- Unemployment compensation
- Worker’s compensation
- Social Security benefits
- Other income

Does anyone in your household have any income? □ Yes □ No
If yes, list any income you have already received, or expect to receive, this year.

<table>
<thead>
<tr>
<th>Name</th>
<th>Source of Income (employer, unemployment, social security etc.)</th>
<th>How Often</th>
<th>Amount Before Taxes</th>
<th>Date First Began Mo/Day/Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Weekly, biweekly, monthly, once, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the past year, did anyone (select all that apply):
- Change jobs? □ Yes □ No If yes, who: ________________________________
- Stop working? □ Yes □ No If yes, who: ________________________________
- Start working fewer hours? □ Yes □ No If yes, who: ____________________

Does anyone’s income change from month-to-month? (for example, seasonal employment) □ Yes □ No
If yes, list the person(s) whose income changes, and their total expected income this year, and next year.

<table>
<thead>
<tr>
<th>Name</th>
<th>Total expected income and number of months worked this year</th>
<th>Total expected income and number of months worked next year</th>
</tr>
</thead>
</table>

3c. Tax Deductions

If anyone pays for certain things that can be deducted on a federal income tax return, telling us about them could lower your health insurance cost. You must send us proof of deductions.

These deductions are found on line 23-35 of the 1040 form or lines 16-19 of the 1040A form.

Note: You should not include a cost that you already included in your answer to net self-employment.

Does anyone in your household have any tax deductions? □ Yes □ No
If yes, list any deductions you have already received, or expect to receive.

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Deduction</th>
<th>How Much</th>
<th>How Often</th>
<th>Date First Began Mo/Day/Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3a. Health Insurance:

Medical Assistance can sometimes buy health insurance for you or your children from your employer. Please help us decide if this is possible by completing this section.

Are you offered health coverage from a job? (check yes even if the coverage is from someone else’s job, such as parent or spouse) □ Yes □ No
If yes, complete this section and as much information as you can in Appendix A.

Is this a state employee benefit plan? □ Yes □ No
Is this COBRA coverage? □ Yes □ No
Is this a retiree plan? □ Yes □ No

If you are offered health coverage from your job, do (or would) you have to pay for your coverage? □ Yes □ No
Do (or would) you have to pay for your child(ren)’s coverage? □ Yes □ No

What is the cost to the employee for family coverage through your employer’s group health plan? _________________________

How Often? _________________________ (weekly, bi-weekly, monthly, quarterly, annually)

Did your employer stop offering coverage causing your child to lose health insurance? □ Yes □ No
3. Taxes, Income and Deductions: (continued)

3c. Tax Deductions

If anyone pays for certain things that can be deducted on a federal income tax return, telling us about them could lower your health insurance cost.

You must send us proof of deductions. These deductions are found on line 23-35 of the 1040 form or lines 16-19 of the 1040A form.

Note: You should not include a cost that you already included in your answer to net self-employment.

Does anyone in your household have any tax deductions?

If yes, list any deductions you have already received, or expect to receive.

- Educator expenses
- Certain business expenses of reservists, performing artists, and fee-basis government officials
- Health saving account deduction
- Job-related moving expenses
- Deductible part of self-employment tax
- Self-employed SEP/SIMPLE, and qualified plans
- Self-employed health insurance deduction
- Penalty on early withdrawal of savings
- Alimony paid
- IRA deduction
- Student loan interest deduction
- Tuition and fees
- Domestic production

Tyype of Deduction How Much How Often

Once, Monthly, Quarterly, etc.

Date First Began Mo/Day/Yr

4. Health Insurance:

4a. Health Insurance from your employer

Medical Assistance can sometimes buy health insurance for you or your children from your employer. Please help us decide if this is possible by completing this section.

Are you offered health coverage from a job? (check yes even if the coverage is from someone else's job, such as parent or spouse)  

If yes, complete this section and as much information as you can in Appendix A.

Is this a state employee benefit plan?  

Is this COBRA coverage?  

Is this a retiree plan?  

If you are offered health coverage from your job, do (or would) you have to pay for your coverage?  

Do (or would) you have to pay for your child(ren)'s coverage?  

What is the cost to the employee for family coverage through your employer's group health plan?  

How Often? (weekly, bi-weekly, monthly, quarterly etc.)  

Did your employer stop offering coverage causing your child to lose health insurance?  

You must send us proof of income – see page 3 for valid forms of proof of income.
4b. Health Insurance

If you or someone you are applying for has health insurance coverage, or had health insurance coverage in the recent past, please complete this section. Fill in a box for each policy.

- Does anyone you are applying for have other health insurance today?  ■ Yes  ■ No
- Has anyone you are applying for had health insurance coverage in the last 90 days?  ■ Yes  ■ No

If yes to either question above, please fill in the next section and tell us all you can about the insurance. If no, skip the section.

Policy #1

Types of health care coverage:
- [ ] Employer
- [ ] TRICARE
- [ ] VA health care programs
- [ ] Medicare (Parts A & B)
- [ ] Peace Corps
- [ ] CHIP
- [ ] Medical Assistance
- [ ] Individual plan
- [ ] Other

Insurance Company Name: First name: Last name:
Policy Number: First name: Last name:
Group Number/Name: First name: Last name:

What is/was covered?  ■ Hospital Care  ■ Doctor Visits  ■ Prescriptions  ■ Eye Care  ■ Dental

Is (or was) this a limited-benefit plan (like a school accident policy)?  ■ Yes  ■ No

When did the insurance start? (Mo/Day/Yr)  When will this insurance stop? (Mo/Day/Yr)
(Leave blank if the insurance is not ending)

Did/will this health insurance end because the policy holder lost employment or changed jobs?  ■ Yes  ■ No

If yes, who has lost or will lose coverage?

Policy #2

Types of health care coverage:
- [ ] Employer
- [ ] TRICARE
- [ ] VA health care programs
- [ ] Medicare (Parts A & B)
- [ ] Peace Corps
- [ ] CHIP
- [ ] Medical Assistance
- [ ] Individual plan
- [ ] Other

Insurance Company Name: First name: Last name:
Policy Number: First name: Last name:
Group Number/Name: First name: Last name:

What is/was covered?  ■ Hospital Care  ■ Doctor Visits  ■ Prescriptions  ■ Eye Care  ■ Dental

Is (or was) this a limited-benefit plan (like a school accident policy)?  ■ Yes  ■ No

When did the insurance start? (Mo/Day/Yr)  When will this insurance stop? (Mo/Day/Yr)
(Leave blank if the insurance is not ending)

Did/will this health insurance end because the policy holder lost employment or changed jobs?  ■ Yes  ■ No

If yes, who has lost or will lose coverage?

5. Special Qualifying Information:

If someone you are applying for has a disability or a special health care need, a higher income limit can be used when your family applies for Medical Assistance. Additional services are available. Please help us find out if anyone you are applying for is eligible for these programs.

Does anyone need help paying any medical bills from the last 3 months?  ■ Yes  ■ No
If yes, who?

Does anyone live in a medical or Long Term Care facility or have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)?  ■ Yes  ■ No

**Health Insurance:** (continued)

Are you, or is anyone you are applying for, pregnant?  ■ Yes  ■ No (If yes, tell us who below)
Expected due date: Due date:
How many babies are expected:

Do you or does anyone you are applying for have a permanent disability, a chronic condition, or an ongoing health care need?

Has this person applied for disability benefits?  ■ Yes  ■ No
Has this person applied for disability benefits?  ■ Yes  ■ No

Has this person applied for disability benefits?  ■ Yes  ■ No
Has this person applied for disability benefits?  ■ Yes  ■ No

Has this person applied for disability benefits?  ■ Yes  ■ No
Has this person applied for disability benefits?  ■ Yes  ■ No

Has this person applied for disability benefits?  ■ Yes  ■ No
Has this person applied for disability benefits?  ■ Yes  ■ No

**Pregnancy**

Are you, or is anyone you are applying for, pregnant?  ■ Yes  ■ No (If yes, tell us who below)
Expected due date: Due date:
How many babies are expected:

Do you or does anyone you are applying for have a permanent disability, a chronic condition, or an ongoing health care need?

Has this person applied for disability benefits?  ■ Yes  ■ No
Has this person applied for disability benefits?  ■ Yes  ■ No

Has this person applied for disability benefits?  ■ Yes  ■ No
Has this person applied for disability benefits?  ■ Yes  ■ No

Has this person applied for disability benefits?  ■ Yes  ■ No
Has this person applied for disability benefits?  ■ Yes  ■ No

Has this person applied for disability benefits?  ■ Yes  ■ No
Has this person applied for disability benefits?  ■ Yes  ■ No

**Disability**

Has this person applied for disability benefits?  ■ Yes  ■ No
Has this person applied for disability benefits?  ■ Yes  ■ No

Has this person applied for disability benefits?  ■ Yes  ■ No
Has this person applied for disability benefits?  ■ Yes  ■ No

Has this person applied for disability benefits?  ■ Yes  ■ No
Has this person applied for disability benefits?  ■ Yes  ■ No

Has this person applied for disability benefits?  ■ Yes  ■ No
Has this person applied for disability benefits?  ■ Yes  ■ No

**Foster Care**

Was anyone in foster care at age 18 or older?  ■ Yes  ■ No (If yes, tell us who below)
If yes, did the foster care end because of their age?  ■ Yes  ■ No

Name: In which state: At what age:

Name: In which state: At what age:

Name: In which state: At what age:

Name: In which state: At what age:

Name: In which state: At what age:

Name: In which state: At what age:

Name: In which state: At what age:

Name: In which state: At what age:
### 4. Health Insurance (continued)

**4b. Health Insurance**

If you or someone you are applying for has health insurance coverage, or had health insurance coverage in the recent past, please complete this section. Fill in a box for each policy.

- Does anyone you are applying for have other health insurance today?  
  - Yes  
  - No
- Has anyone you are applying for had health insurance coverage in the last 90 days?  
  - Yes  
  - No

If yes to either question above, please fill in the next section and tell us all you can about the insurance. If no, skip the section.

#### Policy #1

<table>
<thead>
<tr>
<th>Types of health care coverage:</th>
<th>Last who is covered:</th>
<th>Last name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>First name:</td>
<td>Last name:</td>
</tr>
<tr>
<td>TRICARE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VA health care programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare (med A, B, C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peace Corps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHIP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Insurance Company Name:  
  - First name:  
  - Last name: 

- Policy Number:  
  - First name:  
  - Last name: 

- Group Number/Name:  
  - First name:  
  - Last name: 

- What is/was covered?:  
  - Hospital Care  
  - Doctor Visits  
  - Prescriptions  
  - Eye Care  
  - Dental

- Is (or was) this a limited-benefit plan (like a school accident policy)?  
  - Yes  
  - No

- When did the insurance start? (Mo/Day/Yr)  
  - When will this insurance stop? (Mo/Day/Yr)  
  - (Leave blank if the insurance is not ending)

- Did/will this health insurance end because the policy holder lost employment or changed jobs?  
  - Yes  
  - No

If yes, who has lost or will lose coverage?

### Policy #2

<table>
<thead>
<tr>
<th>Types of health care coverage:</th>
<th>Last who is covered:</th>
<th>Last name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer</td>
<td>First name:</td>
<td>Last name:</td>
</tr>
<tr>
<td>TRICARE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VA health care programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare (med A, B, C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peace Corps</td>
<td></td>
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</tr>
<tr>
<td>CHIP</td>
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<tr>
<td>Medical Assistance</td>
<td></td>
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</tr>
<tr>
<td>Individual plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Insurance Company Name:  
  - First name:  
  - Last name: 

- Policy Number:  
  - First name:  
  - Last name: 

- Group Number/Name:  
  - First name:  
  - Last name: 

- What is/was covered?:  
  - Hospital Care  
  - Doctor Visits  
  - Prescriptions  
  - Eye Care  
  - Dental

- Is (or was) this a limited-benefit plan (like a school accident policy)?  
  - Yes  
  - No

- When did the insurance start? (Mo/Day/Yr)  
  - When will this insurance stop? (Mo/Day/Yr)  
  - (Leave blank if the insurance is not ending)

- Did/will this health insurance end because the policy holder lost employment or changed jobs?  
  - Yes  
  - No

If yes, who has lost or will lose coverage?

### 5. Special Qualifying Information:

If someone you are applying for has a disability or a special health care need, a higher income limit can be used when your family applies for Medical Assistance. Additional services are available. Please help us find out if anyone you are applying for is eligible for these programs.

- Does anyone need help paying any medical bills from the last 3 months?  
  - Yes  
  - No

- Does anyone live in a medical or Long Term Care facility or have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)?  
  - Yes  
  - No

**Does anyone live in a medical or Long Term Care facility or have a physical, mental or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)?**

- Are you, or is anyone who lives with you, pregnant?  
  - Yes  
  - No (if yes, tell us who below)

- Date condition/disability was diagnosed:

**Disability Information:**

- What is the disability or condition?  
- Date condition/disability was diagnosed:

**Has this person applied for disability benefits?**

(No Social Security Disability, Supplemental Security Income, Workers’ Compensation, Private Disability Insurance, or Special Assistance with Medical Bills?)

- Yes  
- No

**Pregnancy Information:**

- Name:  
- Due date:

**Has this person applied for pregnancy benefits?**

(Yes Social Security Disability, Supplemental Security Income, Workers’ Compensation, Private Disability Insurance, or Special Assistance with Medical Bills?)

- Yes  
- No

**Do you or does anyone you are applying for have a temporary disability, a chronic condition, or an on going health care need?**

- Yes  
- No (if yes, tell us who and about their needs)

**Has this person applied for disability benefits?**

(Yes Social Security Disability, Supplemental Security Income, Workers’ Compensation, Private Disability Insurance, or Special Assistance with Medical Bills?)

- Yes  
- No

**Foster Care Information:**

- Name:  
- In which state:  
- At what age:

**Has this person applied for foster care benefits?**

(Yes Social Security Disability, Supplemental Security Income, Workers’ Compensation, Private Disability Insurance, or Special Assistance with Medical Bills?)

- Yes  
- No

**Medical Assistance Information:**

- Name:  
- Due date:

**Has this person applied for Medical Assistance benefits?**

(Yes Social Security Disability, Supplemental Security Income, Workers’ Compensation, Private Disability Insurance, or Special Assistance with Medical Bills?)

- Yes  
- No

**Medicare Information:**

- Name:  
- Due date:

**Has this person applied for Medicare benefits?**

(Yes Social Security Disability, Supplemental Security Income, Workers’ Compensation, Private Disability Insurance, or Special Assistance with Medical Bills?)

- Yes  
- No

**Other Information:**

- Name:  
- Due date:

**Has this person applied for other benefits?**

(No Social Security Disability, Supplemental Security Income, Workers’ Compensation, Private Disability Insurance, or Special Assistance with Medical Bills?)

- Yes  
- No
Optional Information: (None of this information will affect your application for health care coverage and will not be passed onto the Health Insurance Marketplace.)

Primary Care Physician (PCP) or Practice Information: If there is a doctor/provider who you would like to have as your child’s PCP, please list below. If that doctor/provider participates with the insurance company you apply with, they may be assigned as your child’s PCP.

If you want to check to see if your doctor participates, please call the insurance company with which you wish to apply.

Is the PCP the same for all children?  □ Yes  □ No   If no, list for each child.

<table>
<thead>
<tr>
<th>Name(s)</th>
<th>Current Patient?</th>
<th>Physician/Practice Name</th>
<th>Physician/Practice Address</th>
<th>Physician/Practice Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>□ Yes □ No</td>
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<td>□ Yes □ No</td>
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<td>□ Yes □ No</td>
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</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Authorized Representative:

You can give a trusted person permission to talk about this application with us, see your information and act for you on matters related to this application, including getting information about and signing your application on your behalf. This person is called an authorized representative. If you ever need to change your authorized representative, contact your CHIP insurance company. If you’re a legally appointed representative for someone on this application, submit proof with the application.

Do you want to name someone as your authorized representative?  □ Yes  □ No

<table>
<thead>
<tr>
<th>Name of Authorized Representative:</th>
<th>Phone Number:</th>
<th>Phone Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ Home □ Work □ Cell</td>
</tr>
</tbody>
</table>

Authorized Representative’s Role:  □ Caregiver □ Legal Guardian □ Primary Contact □ Representative  □ Executor of Living Will □ Power of Attorney □ Support Team Member

Address (include Street, Apt Number, City, State and Zip Code + 4):

By signing below, you allow this person to sign your application, to get official information about this application, and to act for you on all future matters with this policy.

________________________________________  ______________________________________
Your Signature                                      Date

Don’t forget to **sign and date page 13** -- so that your application can be processed.
You have certain rights and responsibilities. They are:

**CHIP:**
- Confidentially – All information on this application will be kept confidential.
- Designate a Personal Representative – You may select another person to receive health related information regarding you or your minor child(ren) by completing a Personal Representative Designation form.
- Certificate of Creditable Coverage – When you leave the program, you will receive a certificate of creditable coverage to verify medical coverage, if you are eligible.
- Written Notice – You will be given a written notice explaining your eligibility.
- Appeal – You may request an impartial review if you do not agree with any decision made regarding this application, if the request is made within 30 days of the decision.

You have a responsibility to:
- Read and fully understand this application.
- Provide true, correct and complete information, understanding that there are penalties for knowingly giving false information, it is a serious offense and considered criminal insurance fraud.
- Help with the review of this application, which may include interviews and reviewing health records.
- Be aware that certain information may be subject to verification from employers, financial sources and other third parties.
- Provide proof of identity and U.S. citizenship or legal immigration status if that information is not obtained through this application process.
- Provide proof of income and tax deductions if that information is not obtained through this application process.
- Report all changes regarding your household including income, family members, address and telephone number as soon as they occur.
- Provide proof that you have health insurance or explain why you do not have one.
- You have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP.
- I understand that I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand that my situation is subject to verification from employers, financial sources and other third parties.
- I understand that Pennsylvania receives information from other state and federal agencies to verify the information I give them. If I do not provide their Social Security Number, it may be used to check the information on this application.
- I understand that the information provided on this application is subject to verification from the Department of Public Welfare if any and all information found on this application is subject to verification from employers, financial sources, and other third parties.
- I understand that the information on this application will be shared only with the Pennsylvania Insurance Department.
- I understand that my Social Security Number is needed and reasonable.
- I understand that the person who is eligible and I may get only the benefits that are required reasonable.
- I understand that Pennsylvania receives information from other state and federal agencies to verify the information I give them. If I do not provide their Social Security Number, it may be used to check the information on this application.
- I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
- If you apply for Medical Assistance before your family's renewal date, letters will be sent requesting verification of income and other family information. If you do not respond within 30 days, your current benefits may be retroactively terminated.
- If your child appears to be eligible for Medical Assistance, we will send your application to the County Assistance Office.
- After we receive your application, we will do an eligibility review and contact you within 30 days.
- If we need more information:
  - We will send you a letter requesting the extra information that we need. Please send us this information right away so we can process your application.
  - If your child is eligible for CHIP:
    - After we check your income and other information, we will notify you of your child’s enrollment date.
    - You will receive your child’s identification card approximately 10 days from the date you become eligible.
    - You can request the type of benefit your child's CHIP coverage on the “effective date” stated in the enrollment letter.
  - If your child is not eligible for CHIP:
    - We will notify you in writing to let you know why your child is not eligible.
    - If your child appears to be eligible for Medical Assistance, we will send your application to the County Assistance Office.

If your child is enrolled in CHIP:
- Once a year, on the anniversary of your child’s enrollment, eligibility will be reviewed. This process is called renewal. Each year, before your family’s renewal date, letters will be sent requesting verification of income and other family information. If you do not provide the information needed, your child’s CHIP coverage will end.

This managed care plan may not cover all of your health care expenses. Read all your materials carefully to determine which health care services are covered.
You have certain rights and responsibilities. They are:

**CHIP:**

- Confidentially – All information on this application will be kept confidential. This application will be shared only with the programs for which you apply and/or may be eligible, such as the Medical Assistance program.
- Designate a Personal Representative – You may select another person to receive health related information regarding you or your minor child(ren) by completing a Personal Representative Designation form.
- Certificate of Creditable Coverage – When you leave the program, you will receive a certificate of creditable coverage to verify medical coverage, if you are eligible.
- Written Notice – You will be given a written notice explaining your eligibility.

You have a responsibility to:

- Read and fully understand this application.
- Provide true, correct and complete information, understanding that there are penalties for knowingly giving false information, it is a serious offense and considered criminal fraud.
- Help with the review of this application, which may include interviews and reviewing health records.
- Be aware that certain information may be subject to verification from employers, financial sources and other third parties.
- Provide proof of identity and U.S. citizenship or legal immigration status if that information is not obtained through this application process.
- Provide proof of income and tax deductions if that information is not obtained through this application process.
- Report all changes regarding your household including income, family members, address and telephone number as soon as they occur.
- **Medical Assistance:**
  - I understand that Pennsylvania receives information from other state and federal agencies to verify the information I give them. If I misrepresent, hide, or withhold facts which may affect my eligibility for benefits, I may be required to repay my benefits, and I may be prosecuted and disqualified from receiving certain future benefits.
  - I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.
  - I understand that the information entered in this application will be kept confidential and used only to administer benefits.
  - I authorize the release of personal, financial and medical information for the purpose of determining eligibility.
  - I understand that any changes I am required to report must be reported within the first 10 days of the month following the change in circumstance.
  - I understand that I will receive a written notice explaining the benefits. If benefits are denied, changed, suspended, or stopped, the written notice will explain why.

I understand that:

- My situation is subject to verification from employers, financial sources and other third parties.
- I understand that applicants must provide their Social Security number or apply for one if they do not have one. This number may be used to check the information on this application.
- I understand that I do not have to provide a Social Security Number for anyone who is not applying for Medical Assistance. If I do provide their Social Security Number, it may be used to check the information on this application.
- I certify that all information that has been entered is true and correct.
- I have the right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health care coverage may be denied or limited for a pre-existing condition. If I enroll in a group health plan that has a pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for CHIP. If I do not qualify for Medical Assistance, I will not be eligible for CHIP.
- I understand that some or all of the individuals applying do not qualify for Medical Assistance, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give my name and information to the Insurance Department or the CHIP contractor.
- **Health Insurance Marketplaces:**
  - I know that I must call the Health Insurance Marketplace if anything changes (such as a different child) what I wrote on this application. I can visit healthcare.gov or call 1-800-318-2525 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
  - I understand that if federal law, discrimination isn’t permitted on submitting it with this application.
  - I understand that I can designate an authorized representative for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give my name and information to the Insurance Department or the CHIP contractor.
  - The marketplace will allow me to compare plans, take a look at the costs, and enroll. The Marketplace will send me an opening notice at least 30 days before the date of the enrollment letter.
  - Yes, renew your marketplace eligibility automatically for:
    - 5 years (the maximum number of years allowed)
    - 4 years
    - 2 years
    - 1 year

Don’t forget to sign and date the application below or it cannot be processed!

I understand that I can designate an authorized representative by completing the Authorized Representative section and submitting it with this application.

If some or all of the individuals applying do not qualify for CHIP, that they may be eligible for federal benefits and/or explore private health care options through the Health Insurance Marketplace. If this is the case, I authorize the Department to give any and all information on this application to the Department of Public Welfare. If any applicants may be eligible for Medical Assistance.

I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP and Medical Assistance programs.

I certify that the person(s) I am applying for are U.S. citizens or aliens in lawful immigration status. (I understand this certification does not apply to an alien who is applying only for Medical Assistance Emergency Health Care benefits.)

I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the program(s) for which I am applying.

What Happens Next

After we receive your application, we will do an eligibility review and contact you within 30 days.

If we need more information:

We will send you a letter requesting the extra information that we need. Please send us this information right away so we can process your application.

If your child is eligible for CHIP:

- After we check your income and other information, we will notify you of your child’s enrollment date.
- You will receive your child’s identification card approximately 10 days from the date you become eligible.
- You can use your child’s CHIP coverage on the “effective date” stated in the enrollment letter.

If your child is not eligible for CHIP:

- We will notify you in writing to let you know why your child is not eligible.
- If your child appears to be eligible for Medical Assistance, we will send your application to the County Assistance Office.

Renewal

If your child is enrolled in CHIP:

- Once a year, on the anniversary of your child’s enrollment, eligibility will be reviewed. This process is called renewal. Each year, before your family’s renewal date, letters will be sent requesting verification of income and other family information. If you do not provide the information needed, your child’s CHIP coverage will end.

This managed care plan may not cover all of your health care expenses. Read all your materials carefully to determine which health care services are covered.
CHIP Companies, listed by county:

**CHESTER**
- Aetna
- UnitedHealthcare Community Plan
- Keystone Health Plan East

**CLARION**
- Highmark Blue Cross Blue Shield
- UnitedHealthcare Community Plan
- UPMC Health Plan

**CLEARFIELD**
- Geisinger Health Plan
- Highmark Blue Cross Blue Shield
- UnitedHealthcare Community Plan
- UPMC Health Plan

**CLINTON**
- First Priority Health (BCNEPA)
- Geisinger Health Plan

**COLUMBIA**
- Capital BlueCross
- Geisinger Health Plan
- Highmark Blue Shield
- UnitedHealthcare Community Plan

**CRAWFORD**
- Highmark Blue Cross Blue Shield
- UnitedHealthcare Community Plan
- UPMC Health Plan

**CUMBERLAND**
- Aetna
- Capital BlueCross
- Geisinger Health Plan
- Highmark Blue Shield
- UnitedHealthcare Community Plan

**DAUPHIN**
- Aetna
- Capital BlueCross
- Geisinger Health Plan
- Highmark Blue Shield
- UnitedHealthcare Community Plan

**DELAWARE**
- Aetna
- UnitedHealthcare Community Plan
- Keystone Health Plan East
- KidsPartners

**ELK**
- Highmark Blue Cross Blue Shield
- UPMC Health Plan

**ERIE**
- Highmark Blue Cross Blue Shield
- UnitedHealthcare Community Plan
- UPMC Health Plan

**FAYETTE**
- Highmark Blue Cross Blue Shield
- UnitedHealthcare Community Plan
- UPMC Health Plan

**FOREST**
- Highmark Blue Cross Blue Shield
- UnitedHealthcare Community Plan
- UPMC Health Plan

**FRANKLIN**
- Aetna
- Capital BlueCross
- Highmark Blue Shield
- UnitedHealthcare Community Plan

**FULTON**
- Aetna
- Capital BlueCross
- Highmark Blue Shield
- UnitedHealthcare Community Plan

**GREENE**
- Highmark Blue Cross Blue Shield
- UnitedHealthcare Community Plan
- UPMC Health Plan

**HUNTINGDON**
- Geisinger Health Plan
- Highmark Blue Cross Blue Shield
- UnitedHealthcare Community Plan
- UPMC Health Plan

**INDIANA**
- Highmark Blue Cross Blue Shield
- UnitedHealthcare Community Plan
- UPMC Health Plan

**JEFFERSON**
- Geisinger Health Plan
- Highmark Blue Cross Blue Shield
- UnitedHealthcare Community Plan
- UPMC Health Plan

**JUNIATA**
- Capital BlueCross
- Geisinger Health Plan
- Highmark Blue Shield
- UnitedHealthcare Community Plan

**LANCASTER**
- Aetna
- Capital BlueCross
- Geisinger Health Plan
- Highmark Blue Shield
- UnitedHealthcare Community Plan

**LAWKAWANNA**
- First Priority Health (BCNEPA)
- Geisinger Health Plan
- UnitedHealthcare Community Plan

**LEBANON**
- Aetna
- Capital BlueCross
- Geisinger Health Plan
- Highmark Blue Shield
- UnitedHealthcare Community Plan

**LEHIGH**
- Aetna
- Capital BlueCross
- Geisinger Health Plan
- Highmark Blue Shield
- UnitedHealthcare Community Plan

**LEHIGH**
- Capital BlueCross
- Geisinger Health Plan
- UPMC Health Plan

**MILLER**
- First Priority Health (BCNEPA)
- Geisinger Health Plan

**MONTGOMERY**
- First Priority Health (BCNEPA)
- Geisinger Health Plan

**NORTHAMPTON**
- Aetna
- UnitedHealthcare Community Plan
- Keystone Health Plan East
- KidsPartners

**PHILADELPHIA**
- Aetna
- UnitedHealthcare Community Plan
- Keystone Health Plan East
- KidsPartners

**PIKE**
- First Priority Health (BCNEPA)
- Geisinger Health Plan
- UnitedHealthcare Community Plan

**POTTERTOWN**
- Geisinger Health Plan
- Highmark Blue Cross Blue Shield
- UPMC Health Plan

**SCHUYLKILL**
- Capital BlueCross
- Geisinger Health Plan
- Highmark Blue Shield
- UnitedHealthcare Community Plan

**SOMERSET**
- Capital BlueCross
- Geisinger Health Plan
- UPMC Health Plan

**SUSQUEHANNA**
- First Priority Health (BCNEPA)
- Geisinger Health Plan
- UnitedHealthcare Community Plan

**TIOGA**
- First Priority Health (BCNEPA)
- Geisinger Health Plan

**UPPER MORELAND**
- First Priority Health (BCNEPA)
- Geisinger Health Plan

Please see the reverse side for contact information and mailing instructions.
With CHIP, you have a choice of companies to administer the health benefits for your child(ren).

Below are the health insurance companies who offer CHIP. Based on the county listings on page 14, please choose the health insurance company in your county you’d like to receive your CHIP coverage through and submit your application to them. Addresses and phone numbers are listed for your convenience. Be sure to write down the phone number of the company you choose so that you can call them with any questions.

You may find that there is more than one CHIP insurance company in your county. We can’t tell you which company to choose, but we can help you make a decision if you are having trouble deciding. If your child currently has a doctor, contact your doctor’s office and find out if he/she participates with the CHIP companies listed below so that you can continue to go to that doctor after you choose the CHIP insurance company. You can also ask people you trust for a doctor they recommend.

<table>
<thead>
<tr>
<th>Company Name</th>
<th>Address</th>
<th>Phone Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>AETNA BETTER HEALTH KIDS — CHIP</td>
<td>P.O. Box 14384, Lexington, KY 40512-9854</td>
<td>1-800-822-2447</td>
<td>860-754-1055</td>
</tr>
<tr>
<td>CAPITAL BLUE CROSS</td>
<td>P.O. Box 777014, 2500 Elmerton Avenue</td>
<td>1-800-543-7101</td>
<td>717-651-8592</td>
</tr>
<tr>
<td>FIRST PRIORITY HEALTH (BCNEPA)</td>
<td>Attn: CHIP 19 N Main St., Wilkes Barre, PA 18711-9989</td>
<td>1-800-543-7199</td>
<td>570-200-6785</td>
</tr>
<tr>
<td>GEISINGER HEALTH PLAN</td>
<td>100 North Academy Avenue, Danville, PA 17822-3220</td>
<td>1-866-621-5235</td>
<td>570-271-5970</td>
</tr>
<tr>
<td>HIGHMARK BLUE SHIELD (CENTRAL PA)</td>
<td>Attn: CHIP P.O. Box CARING, Pittsburgh, PA 15230-9779</td>
<td>1-800-543-7105</td>
<td>866-308-1253</td>
</tr>
<tr>
<td>HIGHMARK BLUE CROSS BLUE SHIELD (WESTERN PA)</td>
<td>Attn: CHIP P.O. Box CARING, Pittsburgh, PA 15230-9779</td>
<td>1-800-543-7105</td>
<td>866-308-1253</td>
</tr>
<tr>
<td>KEYSTONE HEALTH PLAN EAST</td>
<td>Caring Foundation 1901 Market Street</td>
<td>1-800-464-5437</td>
<td>215-241-3679</td>
</tr>
<tr>
<td>KIDZ PARTNERS</td>
<td>P.O. Box 1420, Philadelphia, PA 19105-1420</td>
<td>1-888-888-1211</td>
<td>215-967-9281</td>
</tr>
<tr>
<td>UPMC HEALTH PLAN</td>
<td>P.O. Box 2875, Pittsburgh, PA 15230</td>
<td>1-800-978-8762</td>
<td>412-454-5937</td>
</tr>
<tr>
<td>XEROX UNIPRISE PROJECT</td>
<td>ATTN: UnitedHealthcare Community Plan of PA 3315 Central Ave., Hot Springs, AR 71913</td>
<td>1-800-414-9025</td>
<td>866-888-1129</td>
</tr>
</tbody>
</table>
### Health Coverage From Job(s):

Tell us about the job that offers coverage. Write the person's name who is eligible for coverage, and their Social Security Number, in the Employee Information section and ask your employer to complete the rest of this form. Attach a copy of this page for each job that offers coverage. You DON'T need to answer these questions unless someone in the household is eligible for health coverage from a job.

#### EMPLOYEE Information:
- **Employee Name:**
- **Social Security Number:**

#### EMPLOYER Information:
- **Employer Name:**
- **Employer Address (include street, number, city, state, zip code+4):**
- **Employer Identification Number:**
- **Employer Phone Number:**

#### Who can we contact about employee health coverage at this job?
- **Phone Number (if different from above):**
- **E-mail Address:**

#### Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?
- [ ] Yes  If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (Mo/Day/Yr)
- [ ] No  STOP and return this form to employee.

### Health Coverage From Job(s):

Tell us about the health plan offered by this employer.

Does the employer offer a health plan that covers an employee's spouse or dependent(s)?
- [ ] Yes (which one)  →  [ ] Spouse  [ ] Dependent  [ ] No (go to next question)

Does the employer offer a health plan that meets the minimum value standard?*
- [ ] Yes (go to next question)  →  [ ] No (stop and return form to employee)

For the lowest-cost plan that meets the minimum value standard*, offered only to the employee (don't include family plans):
- If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation program, and didn’t receive any other discounts based on wellness programs.

#### How much would the employee have to pay in premiums for this plan? $

#### How often?
- [ ] Weekly  [ ] Every 2 weeks  [ ] Twice a month  [ ] Quarterly  [ ] Yearly

If the plan year will end soon and you know that the health plans offered will change, go to the next question. If you don’t know, STOP and return form to employee.

#### What will happen to the health coverage plan for the next plan year?
- [ ] Employer won’t offer health coverage  →  [ ] Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question above.)

#### How much would the employee have to pay in premiums for this plan? $

#### How often?
- [ ] Weekly  [ ] Every 2 weeks  [ ] Twice a month  [ ] Quarterly  [ ] Yearly

### Appendix A

#### Appendix B

### Health Care Coverage:

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

#### Note:
- If you have more people to include, make a copy of this page and attach.

### Health Care Coverage: American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Care Coverage.

#### AI/AN Person 1 (Please print all information)

- **Name (First, Middle, Last name):**
- **Member of a federally-recognized tribe?**  [ ] Yes  [ ] No
- **If yes, tribe name and state tribe is located in:**

#### Has this person ever gotten a service from the Indian Health Service, tribal health program, or urban Indian health program, or through a referral from one of these programs?
- [ ] Yes  [ ] No

#### Certain money received may not be counted for Medical Assistance or the Children’s Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:
- Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance.
- [ ] Yes  [ ] No

#### Has this person ever gotten a service from the Indian Health Service, tribal health program, or urban Indian health program, or through a referral from one of these programs?
- [ ] Yes  [ ] No

#### Certain money received may not be counted for Medical Assistance or the Children’s Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:
- Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance.
- [ ] Yes  [ ] No

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*An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60% of each cost (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).
Tell us about the job that offers coverage. Write the person’s name who is eligible for coverage, and their Social Security Number, in the Employee Information section and ask your employer to complete the rest of this form. Attach a copy of this page for each job that offers coverage. You DON’T need to answer these questions unless someone in the household is eligible for health coverage from a job.

**EMPLOYER Information:** The employee needs to fill out this section.

- **Employee Name:**
- **Social Security Number:**

**EMPLOYER Information:** Ask the employer for this information.

- **Employer Name:**
- **Employer Address (include street, number, city, state, zip code+4):**
- **Employer Identification Number:**
- **Employer Phone Number:**
- **Phone Number (if different from above):**
- **E-mail Address:**

Who can we contact about employee health coverage at this job? [ ]

Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?
- [ ] Yes If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (Mo/Day/Yr) ___________
- [ ] No STOP and return this form to employee.

Tell us about the health plan offered by this employer.

- Does the employer offer a health plan that covers an employee’s spouse or dependent(s)?
  - [ ] Yes (which one) → [ ] Spouse [ ] Dependent [ ] No (go to next question)
- Does the employer offer a health plan that meets the minimum value standard? [ ]
  - [ ] Yes (go to next question) → [ ] No (stop and return form to employee)

For the lowest-cost plan that meets the minimum value standard, offered only to the employee (don’t include family plans):
- Does the employer offer a health plan that meets the minimum value standard†?
  - [ ] Yes (go to next question) → [ ] No (stop and return form to employee)

How much would the employee have to pay in premiums for this plan? $ ________ How often?
- [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Quarterly [ ] Yearly

If the plan year will end soon and you know that the health plans offered will change, go to the next question. If you don’t know, STOP and return form to employer.

What change will the employer make for the new plan year?
- [ ] Employer won’t offer health coverage
- [ ] Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.† (Premium should reflect the discount for wellness programs. See question above.)

How much would the employee have to pay in premiums for this plan? $ ________ How often?
- [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Quarterly [ ] Yearly

Date of change (Mo/Day/Yr) ___________

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**American Indian or Alaska Native Family Member (AI/AN)**

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Care Coverage.

**Tell us about your American Indian or Alaska Native family member(s).**

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

**Note:** If you have more people to include, make a copy of this page and attach.

### Appendix A

**AI/AN Person 1**

(Include all information)

- **Name (First, Middle, Last name):**
- **Member of a federally-recognized tribe?** [ ] Yes [ ] No
  - If yes, tribe name and state tribe is located in:

Has this person ever gotten a service from the Indian Health Service, tribal health program, or urban Indian health program, or through a referral from one of these programs? [ ] Yes [ ] No

- Certain money received may not be counted for Medical Assistance or the Children’s Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:
  - [ ] Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties
  - [ ] Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
  - [ ] Money from selling things that have cultural significance.

### Appendix B

**Health Care Coverage: American Indian or Alaska Native Family Member (AI/AN)**

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Health Care Coverage.

**Tell us about your American Indian or Alaska Native family member(s).**

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

**Note:** If you have more people to include, make a copy of this page and attach.

### Appendix A

**AI/AN Person 2**

(Include all information)

- **Name (First, Middle, Last name):**
- **Member of a federally-recognized tribe?** [ ] Yes [ ] No
  - If yes, tribe name and state tribe is located in:

Has this person ever gotten a service from the Indian Health Service, tribal health program, or urban Indian health program, or through a referral from one of these programs? [ ] Yes [ ] No

- Certain money received may not be counted for Medical Assistance or the Children’s Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources:
  - [ ] Per capita payments from a tribe that come from natural resources, usage rights, leases or royalties
  - [ ] Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
  - [ ] Money from selling things that have cultural significance.