



# APPLICATION

For Questions: Call 1-866-864-6142

Mail to: AccessWV  
P.O. Box 3782  
Charleston, West Virginia 25332-3782

## 1. Applicant Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Birth Date (MM/DD/YY) \_\_\_\_\_ Age \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State WV Zip \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ Gender  Male  Female  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Marital Status:  Single  Married  Widowed  Divorced  Separated  
Bill to (Name) *if different than applicant* \_\_\_\_\_ Relationship to Applicant \_\_\_\_\_  
Billing Address (if different than residence) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## 2. Residence

Are you a resident of West Virginia?  Yes  No  
Have you been a resident of West Virginia for at least the last 30 days?  Yes  No

## 3. Eligibility for Public Programs

Have you applied for or are you enrolled in:  
Medicare?  Yes  No  
Medicaid?  Yes  No  
WV CHIP?  Yes  No

If "yes", please explain \_\_\_\_\_

Do you receive Social Security Disability?  Yes  No

If "yes", when do you expect to begin Medicare? \_\_\_\_\_  
Month / Year

## 4. Previous Insurance

Date of Last Health Insurance Coverage \_\_\_\_\_ Name of Last Insurance Company \_\_\_\_\_  
Reason Coverage Ended \_\_\_\_\_

Are you eligible for but NOT enrolled in COBRA?  Yes  No

Have you ever been enrolled in AccessWV?  Yes  No

If "yes", last date of coverage \_\_\_\_\_

## 5. Eligibility Category and Documentation

Please check your basis for eligibility in AccessWV.

**Federally Qualified Eligible Individual through HIPAA who have exhausted Cobra**

**Please attach:**

(1) copy of letter from insurer or employer indicating COBRA coverage has been exhausted.

**Federally Qualified Eligible Individual through HIPAA without Cobra coverage available**

**Please attach:**

(1) copy of letter from insurer or employer indicating that no COBRA is available.

(2) copy of Certificate of Group Health Insurance Coverage

(if no Certificate of Group Health Insurance is available, send explanation of Benefits (EOBs) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, records from medical care providers indicating health coverage, third party statements verifying period of coverage or any other relevant documents that evidence periods of health coverage)

**Person Eligible for the Health Coverage Tax Credit**

**Please attach:**

(1) copy of IRS letter indicating eligibility for HCTC **AND**

(2) copy of letter from employer or insurance carrier, indicating coverage period and last day of coverage.

**Medically Eligible Person**

**Please check the box that describes your situation:**

I was denied health insurance due to health reasons. **Attach copy of denial letter from insurance company dated within the last 6 months.**

I was offered health insurance but it restricted or denied coverage for a medical condition. **Attach a copy of the letter from the insurance company dated within the last 6 months.**

I was offered health insurance, but the premium was higher than AccessWV's premium for similar coverage. **Attach a copy of the letter from the insurance company dated within the last 6 months.**

I have been diagnosed with, or treated for, a medical or health condition that appears on the list of conditions for which a person is eligible for coverage in AccessWV without applying for health insurance. Please check below.

### Qualified Health Conditions

#### Cardiovascular

- Aneurysm
- Angioplasty
- Bypass Surgery
- Congestive Heart Failure
- Coronary Artery Disease
- Heart Attack
- Heart Valve Replacement
- Pacemaker Implant
- Thrombophlebitis
- Valvular Disease

#### Endocrine/Exocrine System

- Diabetes

#### Gastrointestinal

- Cirrhosis of the Liver
- Crohn's Disease
- Ulcerative Colitis
- Hepatitis C

#### Immunological

- AIDS
- AIDS Related Complex
- HIV Positive Status
- Rheumatoid Arthritis
- Systemic Lupus

#### Kidney

- Dialysis
- Renal Failure

#### Musculoskeletal

- Herniated/Degenerative Disc
- Joint Replacement
- Marfan's Syndrome
- Muscular Dystrophy
- Spina Bifida Occua
- Spinal Disorders

#### Neurological

- Alzheimer's Disease
- Cerebral Palsy
- Down's Syndrome
- Parkinson's Disease
- Stroke
- Myasthenia Gravis
- Multiple Sclerosis
- Paralysis

#### Psychiatric

- Psychosis
- Attempted Suicide

#### Pulmonary

- COPD
- Cystic Fibrosis
- Emphysema

#### Other

- Hemophilia
- Infertility Treated with Medications
- Infertility: In Vitro or GIFT
- Pregnancy
- All cancerous conditions within the first five years except Basal Cell (skin) Cancer
- Applicant has been advised to have surgery that has not yet been performed. Please indicate the reason for the surgery and if it is scheduled, and for what date. Surgery for:

\_\_\_\_\_

\_\_\_\_\_

Surgery date: \_\_\_\_\_

**6. Other Eligibility Information**

**Employment (If applicant is a child, please provide information for the parents' employers.)**

Are you?  an employee  self-employed  not employed  retired

**Employer** \_\_\_\_\_

Name Street Address City State

Does your employer offer health insurance to its employees?  Yes  No

If "yes", why are you not covered? \_\_\_\_\_

**Spouse's employer** \_\_\_\_\_

Name Street Address City State

Does your spouse's employer offer dependent health insurance coverage?  Yes  No

If "yes", why are you not covered? \_\_\_\_\_

**7. Statistical Information**

What is your total annual gross household income? Gross income is your income before taxes and any other deductions.  \$0- \$19,999  \$20,000- \$39,999  \$40,000- \$59,000  \$60,000+

What is your current household size? Include your spouse and all dependents living in your household whether or not they may be covered by AccessWV. \_\_\_\_\_ persons in household  
Number

**8. Plan You Wish to Select**

Plan A  Plan B  Plan C  Plan D

**9. Kind of Coverage**

Single Coverage  Family Coverage

**Dependent Information**

	Last Name	First Name	MI	Gender	Birth date	Soc. Sec. #
Spouse						
Child						
Child						
Child						
Child						

Are any of the listed dependents eligible for Medicare, Medicaid or WV CHIP?  Yes  No  
(If applicant is HIPAA eligible, are any listed dependents eligible for Medicare or Medicaid?)  Yes  No

If "yes" provide details \_\_\_\_\_

**10. Premium Payment**

*For your coverage to become effective, you must submit the first month's premium with your application and make arrangements for future payments. If you are NOT approved, your check will be returned to you.*

**NOTE:** AccessWV does NOT accept third party checks for payment of premiums. Your premium must be paid by your own personal check or that of a spouse, a parent (in the case of a minor child) or an adult child. You may also pay by money order. A third party check, including one drawn on a business account, will not be accepted, and your application will be returned.

**Premium Payment:** \_\_\_\_\_  
Amount paid

**ATTACH FIRST MONTH'S PAYMENT HERE**

**11. Affidavit Related to Premium Payment**

I certify that neither my employer nor my spouse's employer is paying for my AccessWV premiums. No employer will be reimbursing me for premiums which I pay to AccessWV. I certify that no health care provider is paying for my AccessWV premiums. No health care provider will be reimbursing me for premiums which I pay to AccessWV. I understand that if either of the above statements is false, AccessWV may cancel any health insurance provided to me as if it had never been in effect and take any other action allowable to it by law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

**12. Future Method of Premium Payment**

- I will pay directly on a monthly basis.
- I wish to arrange for automatic payment to be deducted directly from my bank account on a monthly basis. ***(Please complete Authorization on page 8 (back page) of this Application.)***



#### 14. Affirmations and Understandings

I understand that I am applying to AccessWV offered by the Offices of the Insurance Commissioner, an agency of the State of West Virginia, for an individual policy of hospital, medical, surgical, and prescription insurance. I also understand that my coverage will become effective on the first day of the month following approval and acceptance of the application by AccessWV. I understand that I will be responsible for paying premiums from my effective date forward. I affirm that the answers on this application are complete and correct. I understand that, if convicted of perjury by providing inaccurate or incomplete information, I may be sentenced to not less than one year and no more than 10 years in jail.

1. Under penalty of perjury, I certify that I am a resident of the State of West Virginia and that I will continue to be legally domiciled and physically present in the State of West Virginia for the foreseeable future. I further certify that the residence listed as the Street Address is my permanent residence. I understand that if I falsely claim to be a resident of the State, I may be charged with committing perjury.

I also understand that this statement will be relied upon in connection with future renewals of the insurance policy for which I am applying and the payment medical and pharmaceutical claims, and that it is my responsibility to inform AccessWV when I cease to be a West Virginia resident and that I will be subject to the penalties listed above if I fail to do so.

I understand that I will be asked to file an updated certification of residency with AccessWV on at least an annual basis and to provide evidence of my residency. I will cooperate with this request when asked to do so.

\_\_\_\_\_ **Initial here showing you have read and understand the three paragraphs above.**

2. Pre-existing conditions will not be covered until the AccessWV policy has been in effect for six months unless the pre-existing condition limitation period is waived. A pre-existing condition is a condition for which medical advice, care or treatment was recommended or received during the six-month period immediately preceding the AccessWV effective date of coverage. An existing pregnancy is considered a pre-existing condition.

\_\_\_\_\_ **Initial here showing you have read and understand the above paragraph.**

3. If this application contains material misstatements or omissions, generally, and specifically related to **12. Affirmation of Pre-Existing Conditions**, AccessWV may do any or all of the following within two years from the date the policy was issued: a) cancel the agreement as though it had never been effective and refund premiums, less any claims paid; b) deny benefits under the pre-existing condition exclusion period; or c) take any other action available to it by law. This time limit does not apply to fraudulent misstatements. This application is part of any policy issued by AccessWV, in compliance with West Virginia insurance regulations.

\_\_\_\_\_ **Initial here showing you have read and understand the above paragraph.**

4. Through my signature on this application I consent to disclosure to AccessWV of health insurance coverage, health insurance applications, Medicaid, Medicare and WVCHIP eligibility and medical record information about myself and my family members, listed on this application, if needed to: a) determine eligibility for coverage; b) preauthorize or process claims for benefits; c) perform case management (including concurrent review) or quality assurance reviews; or d) conduct an audit. AccessWV shall not release the medical record information it obtains to anyone else except as allowed by state and federal law.

\_\_\_\_\_ **Initial here showing you have read and understand the above paragraph.**

This consent takes effect on the date I sign this application and remains in effect for the lifetime of the AccessWV coverage or the duration of any claim including AccessWV claims against me, whichever is longer.

**15. Certification and Signature**

I certify that all information in this application is true and correct to the best of my knowledge.

Printed name of applicant:

\_\_\_\_\_

Signature of applicant:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**For applicants under the age of 18**, this form must be signed by the custodial parent or legal guardian of the applicant.

I am the  custodial parent **OR**  legal guardian of the applicant (*check one*). I certify that the above statements of the applicant are true and correct to the best of my knowledge.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**16. Authorization Agreement for Monthly Automatic Bank Payment**

**Note: Please complete below if you wish to pay your AccessWV premiums by automatic bank payment. If you plan to pay directly each month by check or money order, you do NOT have to complete this page.**

Name of Applicant or Policyholder: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

I [or we if a joint account] authorize AccessWV to charge my [our] checking account for monthly insurance premiums. I [we] authorize the financial institution named below to honor and pay these monthly charges. This authority is to remain in effect until revoked by me [us] in writing, and until you actually receive such notice. I [we] agree that you shall be fully protected in honoring any such check/draft. I [we] understand that in order to cancel these automatic deductions, I [we] must provide written notice to AccessWV no less than 15 days before the next scheduled automatic deduction.

**YOU MUST ATTACH A VOIDED CHECK WITH THIS AUTHORIZATION AGREEMENT TO BE USED BY THE BANK TO SET UP THE AUTOMATIC PAYMENT**

Authorized Signature: \_\_\_\_\_

Account Number: \_\_\_\_\_

Financial Institution: \_\_\_\_\_

**Note:** If this form is not completed and signed, you will need to pay directly on a monthly basis. You must pay the premium due each month directly by check or money order until your bank processes this authorization or your coverage will be affected.

**Attach Voided Check Here  
For Automatic Payment**

**17. For Use Only When Agent Has Assisted with Application**

**Part 1: AGENT INFORMATION AND SIGNATURE**

**This section is to be filled out by a health agent licensed in West Virginia who has assisted in the completion of this application.**

Agent's Name \_\_\_\_\_ WV Lic. # \_\_\_\_\_ Agent's Phone Number \_\_\_\_\_

I attest that I have assisted the applicant in completing this application for health insurance coverage through AccessWV and request payment of the \$50 referral fee. I have informed the applicant that AccessWV will determine eligibility, the effective date of coverage and whether or not a six-month waiting period for pre-existing conditions will apply. I understand that AccessWV may choose not to pay a referral fee for an incomplete application. Fee will only be paid if the application is accepted and coverage is in effect for at least one month.

I understand that the WV High Risk Pool Statute §33-48-5 prohibits Unfair Referrals to the Plan. *It shall constitute an unfair trade practice for the purposes of article eleven of this chapter for an insurer, insurance agent or insurance broker to refer an individual employee to the plan, or arrange for an individual employee to apply to the plan, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.*

I hereby certify that if the applicant and/or spouse is employed, there is no employer health coverage in effect nor does any employer intend to obtain such coverage within six months of the date of this application.,

Signature of Agent \_\_\_\_\_ Date \_\_\_\_\_

**Part 2 : PAYMENT INFORMATION**

**This section is to be filled out by the health agent who has assisted in the completion of this application.**

A one-time referral fee will be paid to the agent, if the application is complete and approved for coverage in AccessWV. An agent who files an application for him/her self, a relative or a member of his/her household is not eligible for a referral fee. The agent may assign payment of the referral fee to a licensed insurance agency. Please provide the information below for the agent (or agency) that is to be paid the referral fee.

Name of Payee \_\_\_\_\_ Tax ID \_\_\_\_\_

Address for Payment \_\_\_\_\_

City or Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**NOTE: A W9 must be submitted for the payee, if this is the first time a request is being made for a referral fee.**

**Part 3: APPLICANT AUTHORIZATION**

**This section should be completed by the applicant, if the applicant wishes to authorize AccessWV to discuss this application and eligibility with the above-named insurance agent. If this is authorization is not provided, any communication about this application will be limited to the applicant.**

I authorize the release of any information which was submitted with my application, as well as all additional information related to my eligibility and enrollment determination, whether sent with my application or after my application was first received by AccessWV to the insurance agent named in Part 1 above. I authorize AccessWV to involve the above named agent in any attempt to secure additional information needed to process my application.

This authorization for use/disclosure is solely for my application to AccessWV. This authorization will remain effective until 30 days following the final disposition of my application (approval, withdrawal, denial).

However, I understand that I have the right to revoke/withdraw this authorization, in writing, at any time, and that the revocation/withdrawal will be effective except to the extent that AccessWV has already taken action in reliance on my authorization. My written statement that I want to revoke/withdraw my authorization should be delivered to the address listed below.

I understand that this authorization is voluntary. Enrollment or eligibility for benefits for my health care will not be affected if I do not sign this form. Information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving this information. I should retain a signed and dated copy of this authorization form for my records.

Print Name of Applicant \_\_\_\_\_

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

**For Office Use Only**

***Date Coverage Effective*** \_\_\_\_\_

***Referral fee authorized*** \_\_\_\_\_  
Wells Fargo Signature

\_\_\_\_\_ Date