



ARKANSAS COMPREHENSIVE HEALTH INSURANCE POOL (CHIP)

Applicant's Name

P.O. Box 1460 Little Rock, AR 72203

Application for CHIP Coverage Health Coverage Tax Credit (HCTC) Eligible Persons

INTRODUCTION: This application for CHIP Coverage contains an Eligibility Worksheet and two Enrollment Forms. First, please answer the Eligibility Worksheet and follow its instructions. The Eligibility Worksheet helps you figure out if you may be eligible for CHIP coverage and shows you which Enrollment Form to fill out. Next, fill out the appropriate Enrollment Form. Finally, send both your completed Eligibility Worksheet and whichever Enrollment Form you fill out to CHIP Program, P. O. Box 1460, Little Rock, AR 72203.

ELIGIBILITY WORKSHEET

PART ONE: RESIDENCY AND NOTICE OF POTENTIAL ELIGIBILITY FOR TAX CREDIT

1. Have you received a letter from the Health Coverage Tax Credit (HCTC) Processing Center or a federal agency notifying you that you are or may be eligible for the federal Health Coverage Tax Credit?
[] No If you answered NO, STOP. You cannot apply for CHIP coverage until you receive this written notice.
[] Yes If you answered YES, please attach the letter, filling out all questions asked on the letter.
2. Are you a current resident of Arkansas?
[] No If you answered NO, STOP. You are not eligible for CHIP coverage if you do not currently reside in Arkansas.
[] Yes If you answered YES, proof of residency MUST be attached to this application. Proof of residency must include the written notice you provide under Question 1, above, showing an Arkansas address, and at least one other document, such as a copy of your current driver's license or your most recent Arkansas tax return or utility bill.

PART TWO: APPLICANT AND DEPENDENTS' ELIGIBILITY FOR TAX CREDIT

- If you are eligible for the Health Coverage Tax Credit (HCTC Eligible), your spouse and other dependents also may be eligible for coverage. A dependent generally is anyone you can claim as a dependent on your federal income taxes. However, in the case of divorced parents, you must be a custodial parent to receive the tax credit. If your spouse or other dependents are eligible and enroll for CHIP coverage, a separate policy will be issued to each such dependent.
To verify that you, your spouse and your dependents are HCTC Eligible, please answer the following questions. Attach additional sheets if necessary.

1. Can you be claimed as a dependent on your parent's or some other person's federal tax return? [] Yes [] No
If you answered YES, STOP. You are not eligible for the tax credit. If you answered NO, continue.
2. Are you currently incarcerated by a federal, state or local authority? [] Yes [] No
If you answered YES, STOP. You are not eligible for the tax credit. If you answered NO, continue answering the following questions about you, your spouse and dependents.
Table with 6 columns: Question, Self, Spouse, Dependent, Dependent, Dependent. Row 3: Are you or your dependents currently enrolled in or eligible for Medicare, Part A or Part B?

	Self	Spouse	Dependent	Dependent	Dependent
4. Are you or your dependents currently enrolled in any of the following plans or programs?					
a. The Arkansas Medical Assistance Program (Medicaid or ARKids)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. A federal employee health plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. A U.S. military health plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. A health plan provided through your or your spouse's current or former employer that contributes more than 50% of your family's premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. A plan provided through you or your spouse's current or former employer that provides coverage in lieu of cash or other benefits under a cafeteria plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered YES to ANY ONE of these questions about yourself, STOP. You and your dependents ARE NOT eligible for CHIP HCTC coverage.					
If you answered NO to all of these questions about yourself, but answered YES about any dependent, that dependent IS NOT eligible for coverage. Please continue the application for yourself and all other dependents.					

PART THREE: IS APPLICANT A HCTC QUALIFIED ELIGIBLE PERSON?

This section will help you to determine whether to fill out the HCTC Qualified Eligible Enrollment Form beginning on page 4 of the application or the HCTC Standard Eligible Enrollment Form beginning on page 7 of the application. The questions in Part 3 apply only to yourself and not to any of your dependents.

- To be a HCTC Qualified Eligible Person, you must have had "creditable coverage" for at least 3 months without a break of 63 consecutive days or more. Your last coverage must have ended no more than 63 days before the date you complete and sign this application.
- Creditable coverage* includes most forms of health insurance, including individual coverage, coverage through group plans sponsored by an employer, the federal government or a state, COBRA or continuation coverage, and coverage provided under a qualified risk pool such as CHIP. (Your Outline of Coverage contains a definition of "creditable coverage.")*

1. Have you had creditable coverage* within the 63 days prior to the date that you complete this application? • If you answered YES, continue with Question 2. If you answered NO, STOP, and skip to the HCTC Standard Eligible Enrollment Form beginning on page 5.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. If you answered YES to question 1, were you covered by the creditable coverage* for 3 consecutive months or more? • If you answered YES, skip to question 4. If you answered NO, proceed to question 3.	<input type="checkbox"/> Yes <input type="checkbox"/> No

* "Creditable coverage" does not include the following types of coverage: accident-only, disability income, liability, auto (including auto medical payment), credit-only or workers compensation insurance; on-site clinic plans; dental-only or vision-only plans; long-term care plans; specific disease plans or hospital indemnity plans, when not offered in coordination with a group health plan; supplemental plans such as Medicare supplement, CHAMPUS supplement or hospital supplement plans.

<p>3. If you answered NO to question 2, were you covered for a <u>total</u> of 3 months without a break in coverage of 63 days or more?</p> <ul style="list-style-type: none"> • If you answered YES, proceed to question 4. • If you answered NO to question 3, STOP, and skip to the HCTC Standard Eligible Enrollment Form beginning on page 7. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>4. Do you have a certificate or certificates of creditable* coverage from an insurance company or employer showing that you have been covered for a total of 3 months without a break in coverage of 63 days or more?</p> <ul style="list-style-type: none"> • If you answered YES, attach a copy of the certificate or certificates to your application, and fill out the HCTC Qualified Enrollment Form, beginning on page 4 of this application. • If you answered NO, please attach other evidence you have of the creditable coverage, if any, such as benefit forms or premium invoices from the health insurer that covered you, and provide the following information for each health insurance policy or plan under which you were covered (attach additional sheets if necessary). After providing the following information, fill out the HCTC Qualified Enrollment Form, beginning on page 4 of this application. 	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Insurer/Group Health Plan:	Dates of Coverage:	Was this coverage provided through an employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, provide the name and phone number of the employer:

End of Eligibility Worksheet. Enrollment Forms begin on next page.

CHIP

P.O. Box 1460
Little Rock, AR 72203

ARKANSAS COMPREHENSIVE HEALTH INSURANCE POOL (CHIP) HCTC QUALIFIED ELIGIBLE ENROLLMENT FORM

If you are a HCTC Qualified Eligible Person, you and your qualifying family members are guaranteed enrollment in CHIP, upon payment of the first month's premium. There are no preexisting condition limitations.

Please Print All Information.

APPLICANT INFORMATION:						
LAST NAME	FIRST NAME	M.I.	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	DEDUCTIBLE
(Individual eligible for Tax Credit)						<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$1,250 – HSA Qualified
(Spouse)						<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$1,250 – HSA Qualified
DEPENDENTS (FOR FEDERAL INCOME TAX PURPOSES) – INFORMATION – (ATTACH ADDITIONAL SHEETS, IF NECESSARY)						
						<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$1,250 – HSA Qualified
						<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$1,250 – HSA Qualified
						<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$1,250 – HSA Qualified
RESIDENCE ADDRESS						
Street				County		
City	State	Zip Code	Daytime Phone No.		Other Phone No.	
MAILING ADDRESS (IF DIFFERENT)						
Street or P.O. Box						
City	State		Zip Code			
BILLING MODE (Please Check One)						
<input type="checkbox"/> Paid Through Health Coverage Tax Credit (HCTC) Processing Center (see "Important Information About Billing and Payment," below).		<input type="checkbox"/> Monthly Bank Draft To sign up for monthly bank drafts, you MUST sign the Authorization Form in your packet and submit a voided check.			<input type="checkbox"/> Quarterly (After initial billing with your acceptance letter, you will be billed for three months' premium due each January 1, April 1, July 1 and October 1).	
PERSONAL INFORMATION						
Are you or any family members seeking CHIP coverage totally disabled? † <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please identify the person or persons disabled and describe the disability or disabilities:						
Have you or any of your family members used tobacco products in the last 12 months, including any type of lighted pipe, cigar, cigarette or any other smoking equipment filled with tobacco, or any type of smokeless tobacco, such as snuff or chewing tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, identify each person who has used tobacco products in the last 12 months:						
IMPORTANT INFORMATION ABOUT BILLING AND PAYMENT						
1. HCTC Processing Center. Beginning on August 1, 2003, persons eligible for the Health Coverage Tax Credit may receive the credit in advance by enrolling with the HCTC Processing Center. The HCTC Processing Center will collect from you 35% of the total monthly premium for you and each of your covered family members and pay your 35% share and the remaining 65% to CHIP. If you choose this option, you are responsible for sending the HCTC Processing Center the initial billing statement from CHIP and making timely payment to the HCTC Processing Center. If CHIP does not receive the full premium amount from the HCTC Processing Center, you may lose your coverage.						

† A person applying for coverage is considered to be totally disabled if he or she is unable, because of an illness or injury, to perform the material and substantial duties of his or her job. The disability may be temporary or permanent.

2. **Contacting the HCTC Processing Center.** The HCTC Processing Center Customer Contact line is 1-866-628-HCTC (1-866-628-4282). You should contact the HCTC Processing Center about enrolling for the advanced tax credit as soon as you apply for CHIP coverage.
3. **Rates.** The amount of premiums paid by you or your covered family members may vary depending on the deductible level you choose, your age, your gender and whether you have used tobacco products in the last 12 months. Premium rates change on your "0" and "5" birthdays (25, 30, 35, 40, etc.).
4. **Rate increases.** CHIP's rates may increase from time to time. You will have 45 days' notice of any increase. You must **immediately** notify the HCTC Processing Center of the increase, so that it sends the correct full premium to CHIP. **If CHIP does not receive the full premium amount from the HCTC Processing Center, you may lose your coverage.**
5. **Paying CHIP directly.** If you choose to pay premiums to CHIP directly through monthly bank draft or quarterly invoice, you will not be able to receive the advance tax credit. You must pay CHIP IN FULL for all premiums due and claim your tax credit on your tax return.

CERTIFICATION

Please read carefully and sign below.

I hereby apply for CHIP coverage, as offered by the State of Arkansas, for myself and (if applicable) my spouse and/or dependents. I understand and agree to everything listed below:

- I certify that all the information I provided on the Eligibility Worksheet and this HCTC Qualified Eligible Enrollment Form about me, my spouse and dependents is true and complete. I understand that coverage for me and my family may be cancelled or rescinded if CHIP determines that I have provided false information.
- I specifically attest that as of the day I am completing this application, I have at least 3 months of prior "creditable coverage" (as defined in the Outline of Coverage provided to me with this application) without a break in coverage of 63 days or more. I agree to cooperate with CHIP in verifying this creditable coverage.
- If the premiums are not paid in full within 31 days after the due date, my coverage and/or my spouse and dependent's coverage will end as of the date payment was due.
- I certify that I am legally domiciled in the State of Arkansas as of the date of this application.
- I understand that if accepted I, my spouse, and each dependent will be issued a separate policy that explains each of our rights and responsibilities and that failure to follow the requirements of the policy may result in its cancellation.
- I also understand that the continued eligibility for me, my spouse, and dependent(s) coverage depends upon me continuing to be a HCTC Qualified Eligible Person and that should my CHIP coverage be terminated for any reason, my spouse and dependent(s) coverage will also automatically terminate on the effective date of the termination of my coverage.

Any person who knowingly presents false information in an application for insurance, or knowingly presents a false or fraudulent claim for payment of a loss or benefit, violates both state and federal law and may be subject to fines or imprisonment.

Signed at:	City	State	ZIP
Applicant's signature:	X	Date signed:	
Parent/Guardian's signature (if for minor/incompetent)	X	Date signed:	

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

Print Agent's Name	Social Security No.	Agency	Phone Number
Agent's Signature & Date	Address	City	State ZIP

FOR OFFICE USE ONLY (Do NOT write in this space.)

Division No.	Effective Date

End of HCTC Qualified Eligible Enrollment Form.

Return this Enrollment Form with your Eligibility Worksheet.



**ARKANSAS COMPREHENSIVE HEALTH INSURANCE POOL (CHIP)
HCTC STANDARD ELIGIBLE ENROLLMENT FORM**

P.O. Box 1460
Little Rock, AR 72203

Please Print All Information.

APPLICANT INFORMATION:						
LAST NAME	FIRST NAME	M.I.	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	DEDUCTIBLE
(Individual eligible for Tax Credit)						<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$1,250 – HSA Qualified
(Spouse)						<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$1,250 – HSA Qualified

DEPENDENTS (FOR FEDERAL INCOME TAX PURPOSES) – INFORMATION – ATTACH ADDITIONAL SHEETS, IF NECESSARY)						
						<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$1,250 – HSA Qualified
						<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$1,250 – HSA Qualified
						<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$1,250 – HSA Qualified

RESIDENCE ADDRESS					
Street				County	
City	State	Zip Code	Daytime Phone No.	Other Phone No.	

MAILING ADDRESS (IF DIFFERENT)		
Street or P.O. Box		
City	State	Zip Code

BILLING MODE (Please Check One)		
<input type="checkbox"/> Paid Through Health Coverage Tax Credit (HCTC) Processing Center (See "Important Information About Billing and Payment," below).	<input type="checkbox"/> Monthly Bank Draft To sign up for monthly bank drafts, you MUST sign the Authorization Form in your packet and submit a voided check.	<input type="checkbox"/> Quarterly (After initial billing with your acceptance letter, you will be billed for three months' premium due each January 1, April 1, July 1 and October 1).

PERSONAL INFORMATION
Are you or any family members seeking CHIP coverage totally disabled? ‡ <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please identify the person or persons disabled and describe the disability or disabilities:

Have you or any of your family members used tobacco products in the last 12 months, including any type of lighted pipe, cigar, cigarette or any other smoking equipment filled with tobacco, or any type of smokeless tobacco, such as snuff or chewing tobacco? Yes No If YES, identify each person who has used tobacco products in the last 12 months:

CURRENT HEALTH CARE COVERAGE INFORMATION ABOUT APPLICANT

Please answer the following questions 1-6 about yourself only.

1. Are you currently enrolled in, or *eligible for*, health insurance coverage, including Medicare, employer coverage as an employee or dependent, or as a Medicaid recipient? Yes No

If you answered NO, skip to question 2. If you answered YES, provide the following additional information:

a. Your current coverage

i. Name of primary person covered: _____

ii. Name of insurer/group health plan: _____

iii. Is this coverage provided through an employer? Yes No

b. Are you currently satisfying a waiting period for coverage? Yes No

‡ A person applying for coverage is considered to be totally disabled if he or she is unable, because of an illness or injury, to perform the material and substantial duties of his or her job. The disability may be temporary or permanent.

If you answered YES:

- i. What date did the waiting period begin? _____
- ii. When will the waiting period end? _____

c. Does your existing health insurance coverage offer substantially similar or more comprehensive benefits than this CHIP policy *at a rate of at least 50% in excess of the applicable premium under this CHIP policy*? Yes No

If YES, please attach a copy of the most recent billing statement for each insurance company.

d. Do you intend to cancel your existing health insurance coverage if you are approved for this CHIP policy? Yes No

2. Have you been rejected or refused by an insurer to issue substantially similar **individual** health insurance coverage by reason of the existence or history of a medical condition? Yes No

If "Yes," please attach a copy of the notice from the insurer.

3. Have you received notice from an insurer refusing to issue individual health insurance coverage except at a rate at least 50% in excess of the applicable premium rate under this CHIP policy? Yes No

If "Yes," please attach a copy of the notice from the insurer.

4. Has your insurance through CHIP been canceled within the last twelve (12) months? Yes No

5. Have you received prior CHIP covered expenses or benefits of any kind in excess of \$1,000,000? Yes No

6. If you recently moved to Arkansas, were you most recently covered by another state's health insurance risk pool? Yes No

If YES, please identify the state in which you were covered and your policy or I.D. number. _____

Please identify the date your coverage terminated, or provide a **Certificate of Creditable Coverage from the risk pool.** _____

PURCHASE OF RIDER WAIVING THE PRE-EXISTING CONDITION EXCLUSION: Unless you and/or your dependents are eligible to purchase a rider waiving the six month pre-existing exclusion period, and you purchase the rider for yourself and/or your spouse and dependents, you and/or your eligible spouse and dependents will not be covered under this Policy for expenses incurred because of any condition if:

- 1. The condition has manifested itself within the six (6) month period immediately preceding the effective date of coverage in such a manner as would cause an ordinary prudent person to seek diagnosis, care or treatment; or
- 2. Medical advice, care or treatment was recommended or received within the six (6) month period immediately preceding the effective date of the coverage. Please answer the following questions to determine if you and/or any of your dependents are eligible to purchase a rider waiving the six-month pre-existing exclusion period.

	Self	Spouse	Dependent	Dependent	Dependent
1. Have you, your spouse or your dependents satisfied a similar pre-existing condition and had coverage for at least six months under a prior individual policy under which you were covered?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you applying for CHIP coverage within 30 days after the coverage for you, your spouse, or your dependents was involuntarily terminated by the insurance carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered YES for yourself, your spouse or any of your dependents, in order to be considered for this Waiver, you must submit a copy of the notice from the insurance carrier canceling your coverage and/or your spouse or dependents' coverage. You will be advised if additional documentation is required to support your request.

COST OF WAIVER: If you, your spouse, or your dependents qualify for the Pre-Existing Condition Exclusion Waiver, you may purchase the Waiver through paying a surcharge of 10% of the individual's otherwise applicable annual premium for as long as that individual's coverage under CHIP remains in effect, or sixty (60) months, whichever is less. The surcharge shall be charged monthly.

Do you want to purchase the Pre-Existing Rider if eligible? Yes No

Identify each person for whom you are purchasing this rider: _____

IMPORTANT INFORMATION ABOUT BILLING AND PAYMENT

- HCTC Processing Center.** Beginning on August 1, 2003, persons eligible for the Health Coverage Tax Credit may receive the credit in advance by enrolling with the HCTC Processing Center. The HCTC Processing Center will collect from you in advance 35% of the total monthly premium for you and each of your covered family members and pay your 35% share along with the remaining 65% of the premium to CHIP.
If you choose this option, you are responsible for sending the HCTC Processing Center the initial billing statement from CHIP and making timely payment of your 35% share of the premium to the HCTC Processing Center. If CHIP does not receive the full premium amount from the HCTC Processing Center, you may lose your coverage.
- Contacting the HCTC Processing Center.** The HCTC Processing Center Customer Contact line is 1-866-628-HCTC (1-866-628-4282). You should contact the HCTC Processing Center about enrolling for the advanced tax credit as soon as you apply for CHIP coverage.
- Rates.** The amount of premiums paid by you or your covered family members may vary depending on the deductible level you choose, your age, your gender and whether you have used tobacco products in the last 12 months. Premium rates change on your "0" and "5" birthdays (25, 30, 35, 40, etc.).
- Rate increases.** CHIP's rates may increase from time to time. You will have 45 days' notice of any increase. You must **immediately** notify the HCTC Processing Center of the increase, so that it sends the correct full premium to CHIP. **If CHIP does not receive the full premium amount from the HCTC Processing Center, you may lose your coverage.**
- Paying CHIP directly.** If you choose to pay premiums to CHIP directly through monthly bank draft or quarterly invoice, you will not be able to receive the advance tax credit. You must pay CHIP IN FULL for all premiums due and claim your tax credit on your tax return.

CERTIFICATION

Please read carefully and sign below.

I hereby apply for CHIP coverage, as offered by the State of Arkansas, for myself and (if applicable) my spouse and/or dependents. I understand and agree to everything listed below:

- I certify that all the information I provided on the Eligibility Worksheet and this HCTC Standard Eligible Enrollment Form about me, my spouse and dependents is true and complete. I understand that coverage for me and my family may be cancelled or rescinded if CHIP determines that I have provided false information.
- If premiums for myself and any covered family member are not paid in full within 31 days after the due date, coverage will end as of the date payment was due.
- I certify that I am legally domiciled in the State of Arkansas as of the date of this application.
- I certify that I am not a resident of a public institution and am not receiving a "benefit payment" from any government program (other than an advance on the federal Health Coverage Tax Credit).
- I certify that if I currently have other health coverage, I will only keep it while I am satisfying the CHIP pre-existing condition waiting period.
- I understand that if accepted I, my spouse, and each dependent will be issued a separate policy that explains each of our rights and responsibilities and that failure to follow the requirements of the policy may result in its cancellation.
- I also understand that the continued eligibility for me, my spouse, and dependent(s) coverage depends upon me continuing to be a HCTC Standard Eligible Person and that should my CHIP coverage be terminated for any reason that my spouse and dependent(s) coverage will also automatically terminate on the effective date of the termination of my coverage.
- I understand the CHIP Program benefits will not be payable during the 6 months after coverage is effective, for any condition that manifested itself in the six months prior to my application for coverage, in such a manner that would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care or treatment was recommended or received during the 6 months prior to the effective date of CHIP coverage. I understand that I may qualify and purchase a waiver of the pre-existing condition exclusion simultaneously with my application for this plan under certain circumstances as set forth in the policy. I understand that pregnancy is one type of pre-existing condition. If I know, or should know from symptoms, that I am pregnant when I apply for CHIP coverage, I understand that services for routine maternity care benefits will be excluded during my first six months of coverage.**

Any person who knowingly presents false information in an application for insurance, or knowingly presents a false or fraudulent claim for payment of a loss or benefit violates both state and federal law and may be subject to fines or imprisonment.

Signed at:	City	State	ZIP
Applicant's signature:	X	Date signed:	
Parent/Guardian's signature (if for minor/incompetent)	X	Date signed:	

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

Print Agent's Name	Social Security No.	Agency	Phone Number
Agent's Signature & Date	Address	City	State ZIP

FOR OFFICE USE ONLY (Do NOT write in this space.)

Division No.	Effective Date	Pre-Existing Waiver ____ Yes ____ No	Pre-Existing End Date

End of HCTC Standard Eligible Enrollment Form.

Return this Enrollment Form with your Eligibility Worksheet.