OKLAHOMA HEALTH INSURANCE HIGH RISK POOL APPLICATION- - -ORIGINAL POLICY

Please print all information.

		Applicant information					**Requested Effective Date:**
1.	A.	Name: Last	First	Middle I	____ Male ____ Female		Date of Birth M/D/Y
	B.	Address: Number	Street	City	State	ZIP	County
	C.	Telephone Number			Social Security No.		
	D.	Person whom OHRP may contact in an emergency: Name: Last	First	Middle	Relationship to you		
	E.	Address: Number	Street	City	State	ZIP	Telephone No. ( )
	F.	Name and address of your employer, if any:					Employer's telephone number ( )
	G.	Are you now totally disabled? If "Yes", please describe your disability. ___Yes ___No					

2. Spouse / Dependents Desiring Coverage

	IDENTIFY RELATIONSHIP	NAME (First, M.I., Last if Different from Applicant)	Social Security Number	BIRTH DATE (Mo-Day-Yr)
M F	SPOUSE			
M F	DEPENDENT 1			
M F	DEPENDENT 2			
M F	DEPENDENT 3			
M F	DEPENDENT 4			

3. OHRP Deductible Selection. Please select the deductible amount you want. Note: Your Spouse and Dependents, **if covered,** will each have the same deductible you select. Each one must satisfy their individual deductibles in each Calendar Year (subject to the family deductible provisions in the Schedule of Benefits).

___$500 ___$1,000 ___$1,500 ___$2,000 ___$5,000 ___$7,500

4. Current Health Care Coverage Information

A. Are you employed? Yes___ No___ Is your spouse employed? Yes ___ No___.

B. Are you covered by group insurance through your employer? Yes ___ No___.

Are you covered by group insurance through your spouse's employer? Yes ___ No___.

C. Are you currently enrolled in, or eligible for, Medicare or Medicaid? Yes___ No___.

D. Have you previously had company sponsored coverage terminated? Yes___ No___.

E. Do you have health insurance presently in force? Yes ___ No __.

If the insurance to be issued is intended to replace any other accident and health insurance and/or you answered "Yes" to any question, please complete sections F and G below. Attach an extra sheet if necessary. If you answered "No", go on the next section.

F. Name of Primary Person Covered	Name of Insurance Co.	Is this coverage provided by: Your Employer? Spouse Employer?
______________________	____________________	Yes ___ No ___ Yes ___ No ___

G. Have you had continuous coverage under another policy with respect to the given pre-existing condition up to the date of this application? Yes _____ No _____

If you answered "Yes", please complete all information below. If "No", go on to section 6.

Names of Insurance Company	Period of Coverage	Policy Number
______________________	____________________	____________________

5. Are you eligible for or currently covered under COBRA?________(if yes give dates covered)____________

6. Eligibility

I am eligible for coverage with OHRP for the following reasons:

___I am applying for OHRP because of **MEDICAL ELIGIBILITY** please sign AFFIRMATION FORM #1

___I am applying for OHRP coverage because I no longer have or am about to lose group health insurance, COBRA or other coverage and am not eligible for Medicare or Medicaid and I satisfy the definition of a **FEDERALLY DEFINED ELIGIBLE** individual. Please sign AFFIRMATION FORM #2. We will need proof of such prior coverage to establish sufficient aggregate creditable coverage. Acceptable forms of such proof are; certificate of creditable coverage, policy or other insurer letters, pay stubs, billing statements, canceled checks, insurance card, EOB, COBRA election letter, payroll deduction documents, records from health providers, phone calls or statements from third parties, or any other document that evidence periods of health coverage.

X_______________________________________ Date: ____________________

Applicant's Signature if 15 or older
(Parent's or Legal Guardian's Signature for children under 15)

It is not required that you have an insurant agent involved in this application process for OHRP, so you can leave blank the agent's statement below. However, if an agent assists in the process, please ask the agent to complete the following statement.

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

Scott Day	20-2792881	Day Insurance	(785) 291-0200
Print Agents Name	Agent SS Number / Tax ID	Agency	Phone Number
	10036 Westlake Rd.	Ozawkie, KS	66070
Agents Signature	Address	City/State	Zip

OKLAHOMA HEALTH INSURANCE HIGH RISK POOL HEALTH STATEMENT

Your health status does not disqualify you for the OHRP program. However, your answers to these questions are important to the operation of the program.

Each of the following questions must be answered "Yes" or "No". In addition, each condition which caused you to answer "Yes" must be circled, and described on the next page.

Your policy will not cover expenses incurred during the first 12 months after its Effective Date of Coverage for a pre-existing condition. A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment (including prescriptions) was recommended or received within the six month period ending on the enrollment date. This provision does not apply to federally qualified individuals.

During the past two years, have you had or been advised of, positively diagnosed with, or treated for any of the following conditions?

1. Anemia, other blood disease or disorder ___ Yes ___ No
2. Arthritis, lupus, gout or any inflammation, recurrent pain or diminished range of motion in the joints, including knees or hips (please indicate the specific problem on the following page) ___ Yes ___ No
3. Back, neck or spinal column disorders, including back adjustments recurrent back pain or immobility ___ Yes ___ No
4. Bladder infections, kidney infections, kidney stones, or any other bladder, kidney or urinary disorder ___ Yes ___ No
5. Breast disorder, fibrocystic disease, breast implant or reduction ___ Yes ___ No
6. Cancer, cysts, tumors, polyps, or other growths ___ Yes ___ No
7. Congenital disease or birth defect ___ Yes ___ No
8. Diabetes, goiter or thyroid disorder or disorder of the glands ___ Yes ___ No
9. Acquired Immune Deficiency Disorder (AIDS) or related complex (ARC) ___ Yes ___ No
10. Eating disorder, such as anorexia or bulimia ___ Yes ___ No
11. Emphysema, bronchitis or any chest, lung or respiratory problem or disorder ___ Yes ___ No
12. Epilepsy, seizures, migraine or recurrent headaches ___ Yes ___ No
13. Fractures, dislocations, polio, loss of limb(s), bone disorders (On the following page, please indicate the involved limb(s) [left or right, arm or leg] and if screws, pins or plates are now in place.) ___ Yes ___ No
14. Gallstones, gallbladder disorder; hernia (except hiatal) ___ Yes ___ No
15. Sexually-transmitted diseases, such as genital herpes, syphilis, gonorrhea, chlamydia or venereal warts ___ Yes ___ No
16. Heart murmur, irregular heartbeat, rheumatic fever, chest pain, heart valve problem, heart attack or any other heart condition ___ Yes ___ No
17. Hepatitis, cirrhosis or any other liver disorder ___ Yes ___ No
18. Disorder of the male or female reproductive organs, including enlarged prostate, prostatitis, menstrual irregularity or disorder, fibroid uterus, abnormal pap smear or ovarian cyst ___ Yes ___ No
19. Pregnancy ___ Yes ___ No
20. Muscular or neurological disorder, such as muscular dystrophy, multiple sclerosis, cerebral palsy or Parkinson's ___ Yes ___ No
21. Nervous, mental or emotional condition; attempted suicide, depression or mental retardation ___ Yes ___ No
22. Paralysis, stroke, TIA or high blood pressure ___ Yes ___ No
23. Ulcers, colitis, hemorrhoids, ulcerative colitis, Crohn's, hiatal hernia or any other stomach, intestine, bowel or rectal disorder ___ Yes ___ No
24. Varicose veins, clots, poor circulation or any other vein/artery disorder ___ Yes ___ No

During the past two years, have you:

25. Had an operation or been hospitalized? ___ Yes ___ No

26. Been treated or counseled for alcoholism, the use of alcohol, drug abuse or the use of drugs? ___ Yes ___ No

27. Had any other condition, disorder, ailment or injury not listed above for which you have had or plan to seek advice, diagnosis or treatment? ___ Yes ___ No

28. Consulted a doctor, chiropractor, therapist or other health care provider? ___ Yes ___ No

29. If you answered "Yes" to any of the questions number 1-28, complete this section. Give complete details, including the number of each item that you answered "Yes". Attach an additional sheet of paper if necessary.

Item No.	Dates of illness or Conditions or Symptoms	Diagnosis, Treatment, Medication or Reason for Visit	Is further treatment needed?	Were you hospitalized?	Name and Address of Doctor and/or Hospital
	From		-Yes	-Yes	
	To		No	No	
	From		-Yes	-Yes	
	To		No	No	
	From		-Yes	-Yes	
	To		No	No	
	From		-Yes	-Yes	
	To		No	No	

30. Have you taken prescribed medications within the last year? ___ Yes ___ No

If "Yes", please describe below.

Medicine	Dosage	Reason	Name/ Address of Prescribing Doctor

31. Your Current primary physician:

Name:______________________ Specialty:____________________

Address:____________________ Telephone:__________________

City, State, Zip:______________________________________

32. Has future surgery, diagnostic testing or medicinal treatment been recommended or discussed for you? ___ Yes ___ No

If "Yes", complete the following section.

Date ____________________ Diagnosis __________________________

Type of operation or treatment? ____________________________________

X ______________________________________ Date: __________________

Signature of Applicant or Parent or Legal Guardian – Note: If the applicant is under 15 years of age, a parent or legal guardian must sign above to indicate consent.

AFFIRMATION FORM #1
MEDICAL ELIGIBILITY

Please read carefully and sign below.
I hereby apply for OHRP coverage, as offered by the Oklahoma Health Insurance High Risk Pool. I understand and agree to everything listed below:
I certify that all the information I provided on this application is true and complete.
I will pay monthly the premiums billed by OHRP for the benefits that I requested.
If my premiums are not paid within 31 days after the due date, my coverage will end as of the date payment was due.
Any hospital, doctor or other provider of health care services is hereby authorized to release all necessary medical information about my care.

I understand that if I am eligible for OHRP because of medical eligibility, benefits will not be payable during the first 12 months after coverage is effective, for any condition for which medical advice, diagnosis, care or treatment (including prescription medication) was recommended or received during the six month period immediately preceding the effective date of coverage.
I certify that I have been a resident of Oklahoma for at least twelve months prior to making this application.
Proof of my residency (copy of driver's license and/or Oklahoma tax return and/or utility bill) is attached to this application.

I am eligible for coverage with OHRP for the following reasons (please check each that apply):
___ I have applied for health insurance and been rejected by two carriers because of health conditions;
___ I have applied for health insurance and been quoted a rate for coverage substantially more than the Pool's rate; or
___ I have been accepted for health insurance subject to a permanent exclusion or waiver of a pre-existing disease or condition.
___ I have a listed condition.

I understand that my OHRP Contract can be canceled if I provide any false or incomplete information on this application. Then I must repay any benefits that I was not entitled to receive. I understand that this is an application only. I will be notified in writing if I am accepted into the OHRP Program. I understand that I must initial and date any changes I make while I am completing this application.

I will be responsible for obtaining Pre-admission Authorization prior to any non-emergency admission to a hospital or alcoholism treatment facility, and within 72 hours after an emergency admission.

I will let OHRP know if and when I am no longer eligible for OHRP coverage, such as, because I change residence, become eligible for Medicare, or begin receiving Medicaid benefits. Failure to do so will result in repayment of any and all benefits provided to the insured which were paid after the insured failed to meet eligibility requirements.

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to me or any of my dependents which may have a bearing on the benefits payable by this or any other Plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge. A photocopy of this authorization shall be valid as the original.

X________________________________ Date __________
Applicant's Signature if 15 or older (Parent or Legal Guardian's Signature for children under 15)

Signature of Witness ____________________________ Date ________

AFFIRMATION FORM #2
FEDERALLY DEFINED ELIGIBILITY

Please read carefully and sign below.
I hereby apply for OHRP coverage, as offered by the Oklahoma Health Insurance High Risk Pool. I understand and agree to everything listed below:
I certify that all the information I provided on this application is true and complete.
I will pay monthly the premiums billed by OHRP for the benefits that I requested.
If my premiums are not paid within 31 days after the due date, my coverage will end as of the date payment was due.
Any hospital, doctor or other provider of health care services is hereby authorized to release all necessary medical information about my care.

I understand that my OHRP Contract can be canceled if I provide any false or incomplete information on this application. Then I must repay any benefits that I was not entitled to receive.
I understand that this is an application only. I will be notified in writing if I am accepted into the OHRP Program.
I understand that I must initial and date any changes I make while I am completing this application.

I will be responsible for obtaining Pre-admission Authorization prior to any non-emergency admission to a hospital or alcoholism treatment facility, and within 72 hours after an emergency admission.

I will let OHRP know if and when I am no longer eligible for OHRP coverage, such as, because I change residence, become eligible for Medicare, or begin receiving Medicaid benefits.

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to me or any of my dependents which may have a bearing on the benefits payable by this or any other Plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge. A photocopy of this authorization shall be valid as the original.

X_______________________________________ Date ____________
Applicant's Signature if 15 or older (parent or Legal Guardian's Signature for children under 15)

Signature of Witness ______________________________ Date __________