INCLUSIVE HEALTH
FEDERAL OPTION

Application for Coverage

Please mail or forward application to:
Inclusive Health - Federal Option
PO Box 2302
Mt. Clemens, MI 48046-2302
www.InclusiveHealth.org

Please review the eligibility requirements prior to completing this application. Applications will be considered once **all** required information has been received. You must use black or blue ink to complete this form. All required documents must be stapled to the application. If you have questions while completing the application, please call 866-665-2117. **Do not fax application.**

SECTION I: APPLICANT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Social Security #:_____ Date of Birth:_____ Gender: ☐ Male ☐ Female

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

E-mail Address: _____ Total Annual Household Income (optional): _____

Has the applicant used any tobacco products in the last 12 months? ☐ YES ☐ NO

Race/Ethnic Background: (Optional field)

☐ White/Non-Hispanic ☐ Black/African American ☐ Latino/Hispanic ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific

If applicant is a minor or is legally incompetent, supply the following: **All correspondence will be sent to the Parent/Legal guardian.**

Parent/Legal Guardian Name: _____ Parent/Legal Guardian Social Security #: _____

Parent/Legal Guardian Address (if different than above): _____

_____

SECTION II: ELIGIBILITY INFORMATION

You must be uninsured or not covered by creditable coverage for at least six months and have a pre-existing condition to be eligible for the Inclusive Health - Federal Option. If you currently have coverage or have had a lapse in coverage of less than 63 days you may want to consider coverage under the Inclusive Health - State Option plan. We encourage you to consult www.inclusivehealth.org or to call 866-665-2117 to consider your options.

1. Are you a resident of the state of North Carolina? ☐ YES ☐ NO
   Please provide a current photocopy of one of the following: NC drivers license or state ID, rent or mortgage payment receipt, voter registration card, state income tax return, property tax receipt or utility bill (If applicant is a minor, the parent or legal guardian will need to supply this information)
   ☐ YES ☐ NO
2. Are you a citizen or legal resident of the United States?
   If you answered "No", please provide a current photocopy of one of the following: NC driver's license or state ID, Visa, I-94, or green card. If green card is pending, a photocopy of your Employment Authorization Document (EAD) and Advance Parole (temporary travel document).
3. Are you eligible for or receiving premium reimbursement for health coverage under any government-sponsored program or by any government agency or health care provider? ☐ YES ☐ NO
4. Are you an inmate or resident of a public institution? ☐ YES ☐ NO
5. I have been without health insurance for at least six (6) months prior to applying for Inclusive Health - Federal coverage and I have a pre-existing medical condition as shown by one of the following (please check all that apply.):

(continued on next page)

SECTION II: ELIGIBILITY INFORMATION (continued)

☐ **I was rejected or refused coverage for health reasons by an insurer**
I must attach a copy of a letter from a health insurer saying they will not provide coverage to me which is dated no more than six months prior to the date of this application.

☐ **I am unable to obtain coverage except with a conditional rider that limits coverage for my high risk condition(s)**
I must attach a copy of the policy including the rider limitations which is dated no more than six months prior to the date of this application.

☐ **I have been diagnosed with a presumptive qualifying medical condition**
I have been diagnosed with one of the medical conditions listed below.

Please check all conditions that apply. You must submit a letter from your physician confirming the diagnosis.

- ☐ Abnormal heart rhythm or palpitations
- ☐ Abnormal lipids incluing high cholesterol or triglycerides **treated with medications**
- ☐ ADD or ADHD treated with medication
- ☐ AIDS/ HIV
- ☐ Alcohol, drug or substance abuse or dependency
- ☐ Allergist visit or immuno therapy injection within last 12 months
- ☐ Alzheimer's Disease
- ☐ Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- ☐ Aneurysm
- ☐ Angina Pectoris
- ☐ Angioplasty
- ☐ Ankylosing Spondylitis
- ☐ Anorexia or Bulimia
- ☐ Anxiety/ Stress/ Panic Disorder
- ☐ Aplastic Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis, such as inflammatory arthritis
- ☐ Asthma treatment or medication within last 24 months
- ☐ Bipolar Disorders
- ☐ Brain Damage
- ☐ Breast biopsies more than 2 in 5 years
- ☐ Cancer (except skin) treated or diagnosed in past 5 yrs
- ☐ Cardiac bypass surgery
- ☐ Cardiomyopathy
- ☐ Cataracts or Glaucoma
- ☐ Cerebral Palsy
- ☐ Cerebral shunt placement
- ☐ Chiropractic or physical therapy treatment more than 5 times in last year
- ☐ Chronic Bronchitis
- ☐ Chronic fatigue
- ☐ Chronic hepatitis B, C or D
- ☐ Chronic kidney disease
- ☐ Chronic lyme disease
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Chronic Pancreatitis
- ☐ Cirrhosis of the Liver
- ☐ Cochlear implant
- ☐ Colitis, Crohn's, irritable bowel syndrome, inflammatory bowel disease, familial polyposis
- ☐ Congestive Heart Failure (CHF)
- ☐ Connective Tissue Disorder
- ☐ Coronary Heart Disease
- ☐ Coronary Insufficiency
- ☐ Cystic Fibrosis
- ☐ Deep Venous Thrombosis (DVT)
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes - Type I or Type II
- ☐ Disc disorder including surgery or injection therapy in the last year
- ☐ Diverticulitis
- ☐ Down's Syndrome
- ☐ Emphysema
- ☐ Endometriosis, uterine fibroids
- ☐ Epilepsy, or seizure disorder
- ☐ Epstein Barr
- ☐ End Stage Renal Disease (ESRD)
- ☐ Fibromyalgia
- ☐ Friedreich's Ataxia
- ☐ Gall bladder disease with gall stones but without removal of gall bladder
- ☐ Gastric bypass or gastric restrictive procedures like lap band
- ☐ Gastro esophegeal reflux disorder treated with medication or surgery
- ☐ Heart valve replacement
- ☐ Hemochromatosis
- ☐ Hemophilia
- ☐ Hodgkin's Disease
- ☐ Huntington's Chorea
- ☐ Hydrocephalus
- ☐ Hypertension
- ☐ Interstitial lung disease
- ☐ Kidney disease being treated with medications such as Procrit, or Epogen
- ☐ Kidney disease requiring dialysis
- ☐ Kidney or bladder stones
- ☐ Knee, hip or joint replacement recommended or existing
- ☐ Leukemia
- ☐ Lupus Erythematosus Disseminate
- ☐ Major Organ Transplant
- ☐ Malignant Lymphoma
- ☐ Melanoma
- ☐ Migraines or chronic headaches
- ☐ Mitral valve prolapse
- ☐ Motor/ Sensory Aphasia
- ☐ Multiple or Disseminated Sclerosis
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Myocardial Infarction (heart attack)
- ☐ Mytonia
- ☐ Obsessive Compulsive Disorder
- ☐ Open Heart Surgery
- ☐ Organ Transplant
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Other immune deficiency disorders
- ☐ Pacemaker
- ☐ Paget's Disease
- ☐ Paralysis
- ☐ Paraplegia or Quadriplegia
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease (PVD)
- ☐ Permanent colostomy/ ileostomy
- ☐ Polio
- ☐ Polyarteritis (periarteritis nodosa)
- ☐ Polycystic kidney disease
- ☐ Primary cardiomyopathy
- ☐ Progressive Systemic Sclerosis (Scleroderma)
- ☐ Prostate disorders, including enlarged prostate, benign prostatic hypertrophy or elevated PSA
- ☐ Psoriasis moderate or severe
- ☐ Psoriatic Arthritis
- ☐ Psychotic Disorder
- ☐ Pulmonary Hypertension
- ☐ Raynaud's Disease
- ☐ Rheumatoid Arthritis
- ☐ Schizophrenia
- ☐ Sexually Tansmitted Diseases including chlamydia genital warts, gonorrhea, syphilis, Human Papiloma Virus
- ☐ Sickle Cell
- ☐ Sleep Apnea
- ☐ Spinal Fusion
- ☐ Stroke (CVA)
- ☐ Suicide Attempt
- ☐ Syringomyelia
- ☐ Tetrology of Fallot
- ☐ Thalassemia Major
- ☐ Tobacco use within last 12 months
- ☐ Transient ischemic attack
- ☐ Valvular heart disease
- ☐ Von Willebrand's
- ☐ Wilson's disease

SECTION III: OTHER INSURANCE INFORMATION

1. Indicate your Employment Status (This question must be completed by the applicant. If applicant is a minor child, skip to question #2)

☐ Employed Full Time ☐ Employed Part Time ☐ Self-Employed ☐ Not Employed ☐ Retired ☐ Disabled

a. If employed, please complete the information below:

Employer Name: _____

Employer Address: _____

Employer City, State & Zip: _____

Employer Phone Number: _____

Date of Hire: _____

Are you enrolled in the health insurance coverage offered by your employer? ☐ YES ☐ NO

b. If *not* employed, please complete the information below:

Date of Last Employment: From: _____ To: _____

Were you enrolled under this in the Employer health plan? ☐ YES ☐ NO

c. If retired, please complete the information below:

Date of Retirement: _____

Were you enrolled for coverage under your previous employer's health plan? ☐ YES ☐ NO

d. If disabled, please complete the information below:
Please send a copy of your Social Security Award letter

Are you enrolled in Social Security Benefits? ☐ YES ☐ NO

2. Indicate your **Spouse's** or the **Parent's** Employment Status (If applicant is a minor child, you must supply the following information for both parents and any step-parents)

☐ Employed Full Time ☐ Employed Part Time ☐ Self-Employed ☐ Not Employed ☐ Retired ☐ Disabled

a. If employed, please complete the information below:

Employer Name: _____

Employer Address: _____

Employer City, State & Zip: _____

Employer Phone Number: _____

Date of Hire: _____

Are you enrolled in the health insurance coverage offered by your spouse's or parent's employer? ☐ YES ☐ NO

b. If *not* employed, please complete the information below:

Date of Last Employment: From: _____ To: _____

Was your spouse or parent enrolled for coverage under their last employer's health plan? ☐ YES ☐ NO

c. If retired, please complete the information below:

Date of Retirement: _____

Was your spouse or parent enrolled for coverage under their former employer's health plan? ☐ YES ☐ NO

d. If disabled, please complete the information below:
Please send a copy of your Social Security Award letter

Are you enrolled in Social Security Benefits? ☐ YES ☐ NO

3. Are you enrolled in any other health insurance? ☐ YES ☐ NO

If yes, provide the following information:

Name of Plan or Carrier: _____

Plan or Policy Number: _____

Plan or Carrier Phone Number: _____

4. Are you enrolled in COBRA coverage or state continuation coverage (mini-COBRA) under a group health plan? ☐ YES ☐ NO

SECTION IV: COVERAGE & PAYMENT OPTIONS

1. Please choose one of the Inclusive Health - Federal plan options.
   - ☐ PPO 1000
   - ☐ PPO 2500
   - ☐ PPO 3500
   - ☐ HDHP 4500

If you selected High Deductible Health Plan 4500, you must select one of the three options below:

- ☐ I will be setting up a Health Savings Account (HSA) through the Inclusive Health banking option*
  *You must complete the HSA Bank set-up form and attach to the application (available at www.inclusivehealth.org or call 866-665-2117)
- ☐ I will be setting up a Health Savings Account through my own bank
- ☐ I will NOT be setting up a Health Savings Account

Requested Effective Date: _____

Complete applications received by the 15th of the month can be effective the first of the following month.

Your premium amount is $_____ (refer to premium rate table on our website at www.inclusivehealth.org or call (866) 665-2117)
Your first month's premium will be withdrawn by Electronic Funds Transfer upon the approval of your completed application.

Banking Information

The only available option for your monthly premium payment is via automatic withdrawals taken directly from your checking or savings account, commonly referred to as Electronic Funds Transfer (ETF). Please complete the authorization agreement below and submit a voided check. Your automatic deduction will be made on the last business day of each month for the following month due. In the event that your automatic withdrawal does not go through, there is a possibility of a double withdrawal in one month to bring your premium payments current, or your coverage may be terminated. We reserve the right to add any overdue amounts to the next automatic withdrawal to keep your premium payments current.

Automated Clearinghouse Authorization Agreement

Inclusive Health through its administrator, CoreSource, is hereby authorized to deduct my Inclusive Health premium payment due them by electronic debit entries to my checking or savings account indicated below.

Name of Account Holder: _____
Bank Name: _____
Account Type: ☐ Checking ☐ Savings Account #: _____ Routing No.: _____
Bank Address: _____
City: _____ State: _____ Zip Code: _____
Signature of Account Holder(s): X _____
Account Holder(s) Name(s) (Print): _____
Signature of Account Holder(s): X _____
Account Holder(s) Name(s) (Print): _____

ATTACH A VOIDED CHECK OR SAVINGS ACCOUNT DEPOSIT SLIP HERE

How did you hear about Inclusive Health?

☐ Newspaper ☐ Website ☐ Insurance Company ☐ Employer ☐ Friend
☐ Radio/TV ☐ Health Organization ☐ Insurance Agent ☐ Doctor ☐ Other _____

SECTION V: AGENT INFORMATION (This section should only be completed by the referring agent)

If a North Carolina licensed insurance agent assists you in completing your application for Inclusive Health, Inclusive Health will reimburse the agent a $150 - $200 referral fee if your application is approved and you enroll as a member.

Agent Name: _____
Agent License No. _____ Expiration date: _____
Business/Agency Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ E-mail Address: _____
Make check payable to: _____
Agent Signature: _____ Date: _____
If Inclusive Health does not have a copy of the agent's License and W-9 on file, a copy must be submitted with this application.

SECTION VI: DISCLOSURE AUTHORIZATION AND DECLARATION

By my signature below, I agree to the following statements:

1. The foregoing statements and answers are complete, accurate and true to the best of my knowledge and belief;
2. My coverage will not be effective until the application and any required documentation are received and approved and the full first month's premium has been received and processed. If received by the 15th of the month, the first date that coverage can become effective is the first day of the month following approval by Inclusive Health.
3. I understand that if I am no longer a resident of North Carolina, or if obtain other health insurance coverage, I must notify Inclusive Health and my Inclusive Health coverage will end.
4. I understand that any inaccurate, false, or fraudulent misstatements may lead to rescission of coverage issued or premium rate charged as of the original issue date.
5. I authorize my medical professional, hospital, medical or medical related facility, pharmacy, government agency, insurance agency, health insurance plan, other person or firm, to release my health and eligibility information to Inclusive Health and its administrator, CoreSource, Inc., or their agents, and to accept as valid a photocopy of this authorization and my signature. This includes release of protected health information for claims payment, treatment, utilization review, disease or case management services or quality improvement purposes.
6. I understand that the information provided on this application is considered confidential and is solely for the use of Inclusive Health, and its designated representatives for the purposes of payment, treatment, and health care operations (including care coordination and quality assurance). I understand that information obtained will remain subject to the protections of the Health Insurance Portability and Accountability Act's standards and practices.
7. I understand that this release is valid for 30 months from the date of signature. I understand that I am entitled to receive a copy of this release and that I may revoke this authorization by providing written notice to Inclusive Health or CoreSource, Inc. I understand that If I revoke this authorization, it may affect my enrollment.

Signature of Applicant: _____

Signature of Parent or Legal Guardian: _____
(Minor or legally incompetent)

Date _____

SECTION VII: APPLICATION REQUIREMENTS CHECKLIST

Inclusive Health recommends that you make a photocopy of your application and all supplemental documents for your records.

1. Application for Coverage:
   a. Did you complete the entire application? All required fields must be completed.
   b. Did you sign and date the application?
   c. Did you complete a separate application for each person applying for coverage?

2. Premium Payment (Section IV):
   Did you complete the bank withdrawal form and submit a voided check?
   Your premium payment will be withdrawn from your bank account following the approval of your application.

3. Proof of North Carolina Residency:
   - current North Carolina drivers license or State ID
   - current rent or mortgage payment receipt
   - voter registration card
   - state income tax return
   - property tax receipt
   - utility bill

4. Proof of U S citizenship or Lawful Permanent Resident Alien
   If you answered "No" to question II.2 and did not submit a North Carolina drivers license or state ID in response to question II.1, you must submit one of the following:
   - naturalization/citizenship certificate
   - green card
   - Visa
   - I-94 card
   - Employment Authorization Document (EAD) and Advance Parole

5. Other documentation: (if applicable)
   a. Disability Award Letter
   b. Health Savings Account Banking Set-up form, if using HSA Banking option through Inclusive Health Plan
   c. A letter from a physician verifying the diagnosis for a Presumptive Medical Condition.

Inclusive Health recommends that you make a photocopy of your application and all supplemental documents for your records.

Mail Application, payment and required documentation to:

Inclusive Health - Federal Option
PO Box 2302
Mt. Clemens, MI 48046-2302

****END OF APPLICATION****