North Carolina Health Insurance Risk Pool, Inc.
dba Inclusive Health
Application for Coverage

Please mail or forward application to:
Inclusive Health - State 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

1. I have had a lapse in health insurance coverage of more than 63 days. ☐ YES ☐ NO

   If you anwered "Yes" to question 1, we would encourage you to seriously consider Inclusive Health - Federal Option rather than Inclusive Health - State Option. Under Inclusive Health - State Option you will face a 6 month pre-existing condition waiting period. Inclusive Health - Federal Option requires that you be without creditable coverage for 6 months in order to qualify. For more information, we encourage you to consult www.inclusivehealth.org or to call 866-665-2117 to consider your options.

2. 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)
3. Are you a citizen of the United States? ☐ YES ☐ NO
   If you answered "No", please provide a current photocopy of one of the following: NC drivers 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).
4. Are you a Federally Eligible HIPAA Individual? ☐ YES ☐ NO
   You may qualify as a Federally Eligible HIPAA individual if you have lost health coverage or will soon lose COBRA coverage or state continuation coverage, and all of the following statements are true:

   - Your most recent coverage was not terminated as a result of non-payment of premium or fraud;
   - If offered, you have elected and exhausted any continuation coverage with the most recent coverage under COBRA or state continuation coverage or a similar state or federal program;
   - You did not enroll in an individual insurance policy or accept a conversion policy of limited duration after losing your group coverage;
   - You are not currently eligible for Medicare or Medicaid or any other employment related group health coverage or group health insurance plan;

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SECTION II: ELIGIBILITY INFORMATION (continued)

- You have 18 months of recent creditable coverage under a health plan, with your most recent coverage under an employer sponsored, government, union or church plan;
- You have no more than a 63 day break in coverage since your last coverage terminated.

You must submit a Certificate of Creditable Coverage showing 18 months of continuous coverage without a break in coverage of more than 63 days from your prior carrier. If you are unable to obtain a Certificate of Creditable Coverage, please see Section VIII: Requirements Checklist for other forms of acceptable proof.

5. Are you or any of your legal dependents eligible for the Health Coverage Tax Credit (HCTC) under the Trade Adjustment Assistance (TAA) Reform Act of 2002 or receiving pension payments from the Pension Benefit Guaranty Corporation? ☐ YES ☐ NO

   You are HCTC eligible if you lost your job due to the effects of international trade and are Department of Labor certified:

   - For certain Trade Adjustment Assistance (TAA) or Alternative Trade Adjustment Assistance (ATAA) program benefits
   - For some people who receive benefits from the Pension Benefit Guaranty Corporation and are at least 55 years old

6. 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? **(This excludes the Trade Adjustment Assistance Program (TAA), Alternative Trade Adjustment Assistance (ATAA), and Pension Benefit Guaranty Corporation (PBGC) programs.)** ☐ YES ☐ NO
7. Have you terminated Inclusive Health coverage within the last 12 months? (this question does not apply to you if you answered "Yes" to question 4 or 5)? ☐ YES ☐ NO
8. Are you an inmate or resident of a public institution? ☐ YES ☐ NO
9. Are you eligible for or enrolled in either Medicare Part A or Part B? ☐ YES ☐ NO
10. Are you eligible for or enrolled in the State Medical Assistance Plan or Medicaid? ☐ YES ☐ NO

If you answered "No" to questions 4 and 5 to indicate that you are not in the eligibility category for a Federally Eligible HIPAA individual, and are not in the eligibility category for HCTC, TAA, ATAA, or PBGC qualified individuals, you may still qualify for coverage under Inclusive Health in one of the eligibility categories below. If you answered "Yes" to question 4 or 5 skip to Section III below.

11. Please check the eligibility category that applies to you. I am eligible because of the following options:

a. ☐ **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.

b. ☐ **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.

c. ☐ **My current individual health insurance coverage is at a premium rate exceeding the Inclusive Health premium rate**
I must attach a copy of the premium billing statement that must be dated no more than 60 days prior to the date of this application.

d. ☐ **I was refused individual coverage by an insurer except at a premium rate higher than the Inclusive Health premium rate**
I must attach a copy of the carrier's letter of approval with the required premium listed that must be dated no more than six months prior to the date of this application.

e. ☐ **I am eligible for COBRA or state continuation coverage at an individual rate exceeding my Inclusive Health premium. By selecting this category, I MUST choose one of the eligibility categories a,b,c, or f as also applying to me.**
I must attach a copy of my COBRA Initial Election documents, a state continuation bill or a letter from my employer showing the individual COBRA or state continuation premium.

f. ☐ **I have been diagnosed with a presumptive qualifying medical condition**
I have been diagnosed with one of the medical conditions listed below and am not required to apply for other insurance coverage. Please check all conditions that apply.

☐ AIDS/HIV	☐ Dementia	☐ Myotonia
☐ Alcohol Addiction	☐ Diabetes - Type I or Type II	☐ Open Heart Surgery
☐ Alzheimer's Disease	☐ Emphysema	☐ Paget's Disease
☐ Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)	☐ Friedreich's Ataxia	☐ Paraplegia or Quadriplegia
☐ Aneurysm	☐ Hemochromatosis	☐ Parkinson's Disease
☐ Angina Pectoris	☐ Hemophilia	☐ Polyarteritis (periarteritis nodosa)
☐ Angioplasty	☐ Hepatitis C	☐ Polycystic Kidney
☐ Ankylosing Spondylitis	☐ Hodgkin's Disease	☐ Primary Cardiomyopathy
☐ Anorexia or Bulimia	☐ Huntington's Chorea	☐ Progressive Systemic Sclerosis (Scleroderma)
☐ Aplastic Anemia	☐ Hydrocephalus	☐ Psoriatic Arthritis
☐ Cancer (except skin) treated or diagnosed in past 5 years	☐ Kidney Disease requiring dialysis	☐ Psychotic Disease
☐ Cardiomyopathy	☐ Leukemia	☐ Psychotic Disorder
☐ Cerebral Palsy	☐ Lupus Erythematosus Disseminate	☐ Raynaud's Disease
☐ Chronic Obstructive Pulmonary Disease	☐ Major Organ Transplant	☐ Rheumatoid Arthritis
☐ Chronic Pancreatitis	☐ Malignant Lymphoma	☐ Schizophrenia
☐ Chronic Renal Failure	☐ Malignant Tumors	☐ Sickle Cell
☐ Cirrhosis of the Liver	☐ Melanoma	☐ Stroke (CVA)
☐ Congestive Heart Failure	☐ Motor/ Sensory Aphasia	☐ Suicide Attempt
☐ Coronary Insufficiency	☐ Multiple or Disseminated Sclerosis	☐ Syringomyelia
☐ Coronary Occlusion	☐ Muscular Dystrophy	☐ Tetralogy of Fallot
☐ Crohn's Disease	☐ Myasthenia Gravis	☐ Ulcerative Colitis
☐ Cystic Fibrosis	☐ Myocardial Infarction	☐ Wilson's Disease

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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: _____

Does your employer offer health coverage to its employees? ☐ YES ☐ NO

Are you enrolled for coverage under this plan? ☐ YES ☐ NO

If no, indicate reason why: _____

Please supply a letter from your employer verifying reason for coverage not being available to you.

If yes, does this plan have a pre-existing condition limitation that applies to you? ☐ YES ☐ NO

Please supply a copy of the pre-existing condition limitation and a letter from carrier indicating when it no longer applies to you.

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

Date of Last Employment: From: _____ To: _____

Did your former Employer offer group health coverage? ☐ YES ☐ NO

Were you enrolled for coverage under this plan? ☐ YES ☐ NO

If yes, were you offered or eligible for COBRA or state continuation? ☐ YES ☐ NO

Are you enrolled in a COBRA or state continuation through this employer? ☐ YES ☐ NO

If yes, what is the effective date of COBRA/ state continuation? From: _____ To: _____

If no, are you still within your COBRA election period? ☐ YES ☐ NO

If you are eligible for or enrolled in COBRA or state continuation, you must submit a copy of your COBRA Initial Election documents, a COBRA or state continuation premium bill or a letter from your former employer showing the individual COBRA or state continuation premium.

c. If retired, please complete the information below:

Date of Retirement: _____

Does your former Employer offer group health coverage to Retirees? ☐ YES ☐ NO

If yes, are you enrolled under this plan? ☐ YES ☐ NO

If no, were you offered COBRA or state continuation? ☐ YES ☐ NO

Are you enrolled in this plan under COBRA or state continuation? ☐ YES ☐ NO

If yes, what is the effective date of COBRA/state continuation? From: _____ To: _____

If no, are you still within your COBRA election period? ☐ YES ☐ NO

If you are eligible for or enrolled in COBRA or state continuation, you must submit a copy of your COBRA Initial Election documents, a COBRA or state continuation premium bill or a letter from your former employer showing the individual COBRA or state continuation premium.

d. If disabled, please complete the information below:

Please send a copy of your Social Security Award letter

Do you receive Social Security Benefits? ☐ YES ☐ NO

If yes, what date did your Social Security Benefits begin? _____

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: _____

Does your spouse or parent's employer offer health coverage to its employees? ☐ YES ☐ NO

Are you enrolled for coverage under this plan? ☐ YES ☐ NO

If no, indicate reason why: _____

Please supply a letter from your employer verifying reason for coverage not being available to you.

If yes, does this plan have a pre-existing condition limitation that applies to you? ☐ YES ☐ NO

Please supply a copy of the pre-existing condition limitation and a letter from carrier indicating when it no longer applies to you.

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

Date of Last Employment: From: _____ To: _____

Did your spouse or parent's former Employer offer group health coverage? ☐ YES ☐ NO

Were you enrolled for coverage under this plan? ☐ YES ☐ NO

If yes, were you offered or eligible for COBRA or state continuation? ☐ YES ☐ NO

Are you enrolled in a COBRA or state continuation through this employer? ☐ YES ☐ NO

If yes, what is the effective date of COBRA/ state continuation? From: _____ To: _____

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SECTION III: OTHER INSURANCE INFORMATION (continued)

If no, are you still within your COBRA election period? ☐ YES ☐ NO

If you are eligible for or enrolled in COBRA or state continuation, you must submit a copy of your COBRA Initial Election documents, a COBRA or state continuation premium bill or a letter from your former employer showing the individual COBRA or state continuation premium.

c. If retired, please complete the information below:

Date of Retirement: _____

Does your spouse or parent's former Employer offer group health coverage to Retirees? ☐ YES ☐ NO

If yes, are you enrolled under this plan? ☐ YES ☐ NO

If no, were you offered COBRA or state continuation? ☐ YES ☐ NO

Are you enrolled in this plan under COBRA or state continuation? ☐ YES ☐ NO

If yes, what is the effective date of COBRA/ state continuation? From: _____ To: _____

If no, are you still within your COBRA election period? ☐ YES ☐ NO

If you are eligible for or enrolled in COBRA or state continuation, you must submit a copy of your COBRA Initial Election documents, a COBRA or state continuation premium bill or a letter from your former employer showing the individual COBRA or state continuation premium.

d. If disabled, please complete the information below:

Please send a copy of your Social Security Award letter

Do you receive Social Security Benefits? ☐ YES ☐ NO

If yes, what date did your Social Security Benefits begin? _____

3. Are you eligible for or covered by 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. Have you recently exhausted COBRA coverage or state continuation coverage under a group health plan? ☐ YES ☐ NO

If yes, provide dates of coverage: Effective Date: _____ Termination Date: _____

Please provide a copy of your termination letter indicating reason for termination or a copy of your ID card which indicates who the administrator of the COBRA benefits is. See Section VIII.6 for a list of additional documents that may be submitted.

SECTION IV: INFORMATION ABOUT YOUR HEALTH

If you had previous health coverage that was terminated within 63 days of applying for Inclusive Health, the pre-existing condition waiting period shall be reduced by the amount of time that you had the previous policy of creditable coverage. All other individuals enrolling in Inclusive Health shall be subject to a six month pre-existing condition waiting period.

Note that no pre-existing condition exclusion shall apply to the following:

- A Federally Defined Eligible Individual (If you answered "Yes" to question II.4)
- A TAA, ATAA or PBGC eligible individual (If you answered "Yes" to question II.5)
- A newborn, adopted or foster child for 31 days following the birth or placement in the home as a dependent of an Inclusive Health eligible individual

Please include a copy of your HIPAA certificate of creditable coverage with this application or a copy of the ID card.

See Section VIII.6 for a list of additional documents that may be submitted.

1. Have you been diagnosed, treated or sought any medical advice or treatment during the last 12 months? ☐ YES ☐ NO
2. Have you taken any prescription medication during the last 12 months? ☐ YES ☐ NO

If yes, please list the medication, the medical condition being treated, the date you started taking the medication and the name of the prescribing physician.

NAME OF MEDICATION	MEDICAL CONDITION BEING TREATED	DATE YOU STARTED TAKING MEDICATION	NAME OF PRESCRIBING PHYSICIAN

3. Have you had an operation or been hospitalized during the last 12 months? ☐ YES ☐ NO
4. To the best of your knowledge or belief, have you had or sought treatment or advise or taken any prescription drugs within the last 12 months for any of the following:

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SECTION IV: INFORMATION ABOUT YOUR HEALTH (continued)

Note that all questions must be checked "Yes" or "No" or application will be incomplete. Failure to disclose conditions may result in a delay of claim processing.

a. Cancer, tumor or growth (malignant or benign) ……	☐ YES	☐ NO
b. Acquired Immune Deficiency Syndrome or Human Immunodeficiency Virus positive ……	☐ YES	☐ NO
c. Kidney stones, kidney or bladder condition, urinary frequency or burning ……	☐ YES	☐ NO
d. Diabetes ……	☐ YES	☐ NO
e. Goiter, thyroid condition ……	☐ YES	☐ NO
f. Seizure disorder, central nervous system disorder, multiple sclerosis ……	☐ YES	☐ NO
g. Substance abuse (drug or alcohol dependency, abuse or addiction) ……	☐ YES	☐ NO
h. Use of illicit drugs ……	☐ YES	☐ NO
i. Gall bladder condition, hernia, stomach or intestinal condition, ulcers, hemorrhoids, liver condition ……	☐ YES	☐ NO
j. Cataract or other eye condition ……	☐ YES	☐ NO
k. Chronic Obstructive Pulmonary disease (COPD) ……	☐ YES	☐ NO
l. Asthma ……	☐ YES	☐ NO
m. Tuberculosis, lung condition, bronchitis ……	☐ YES	☐ NO
n. Arthritis, chronic muscular pain, rheumatism, external deformity, amputation(s), back or spinal trouble, limb condition ……	☐ YES	☐ NO
o. Congestive Heart Failure ……	☐ YES	☐ NO
p. Coronary Artery Disease (CAD) ……	☐ YES	☐ NO
q. Hypertension (high blood pressure) ……	☐ YES	☐ NO
r. Other heart condition, hypotension (low blood pressure), rheumatic fever, cerebrovascular accident (stroke) ……	☐ YES	☐ NO
s. Irregular or excessive menstrual bleeding, reproductive system disorders, infertility, breast condition ……	☐ YES	☐ NO
t. Prostate condition, reproductive systems disorders, infertility ……	☐ YES	☐ NO
u. Depression ……	☐ YES	☐ NO
v. Outpatient counseling, any psychiatric or psychological counseling, or any mental disorder ……	☐ YES	☐ NO
w. Sexually transmitted diseases ……	☐ YES	☐ NO
x. Anemia, blood disorders ……	☐ YES	☐ NO
y. Abnormal lab results such as, cholesterol, triglycerides, PSA, Blood sugar, Pap smear, mammography……	☐ YES	☐ NO

SECTION V: COVERAGE & PAYMENT OPTIONS

1. Please choose one of the Inclusive Health plan options.
   - ☐ PPO 1000
   - ☐ PPO 2500
   - ☐ PPO 3500
   - ☐ High Deductible Health Plan 5000

   a. If you selected High Deductible Health Plan 5000, 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, including all document and the bankdraft EFT (Electronic Funds Transfer) information, received by the 15th of the month can be effective the first of the following month. Requested effective dates must be the first of the month with the exception of individuals who are exhausting their COBRA coverage or state continuation coverage. These applicants may request an effective date other than the first of the month that coincides with the last date of such coverage. A completed application, including all documentation and the bankdraft (EFT) information must be received 15 days prior to the effective date of coverage.

Your premium amount is $_____ (refer to premium rate table on our website at www.inclusivehealth.org or call (866) 665-2117

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 (EFT). 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.

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SECTION V: COVERAGE & PAYMENT OPTIONS (continued)

Automated Clearinghouse Authorization Agreement

Inclusive Health through its administrator, CoreSource, Inc., 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 #: _____ 9 digit 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 VI: 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 VII: 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 become effective until the application and any required documentation are received and approved and the first month's premium has been processed via an Electronic Funds Transfer (EFT). 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. If I am exhausting COBRA or state continuation coverage, my coverage will not become effective until at least 15 days after the date my application and any required documentation are received and approved and the full first month's premium and any partial premium for the first month has been processed;
3. I understand that if I am no longer a resident of North Carolina, or if I 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 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 _____

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SECTION VIII: 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 V):**
   Did you complete the bank withdrawal form and submit a voided check?
3. **Proof of North Carolina Residency: Please submit one of the following**
   - current North Carolina drivers license or North Carolina 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.3 and did not submit a North Carolina drivers license or state ID in response to question II.2, you must submit one of the following:
   - naturalization/citizenship certificate
   - green card
   - Visa
   - I-94 card
   - Employment Authorization Document (EAD) and Advance Parole
5. **Proof of Federally Eligible HIPAA individual: (if you answered "Yes" to question II.4)**
   a. Copy of a Certificate of Creditable Coverage showing 18 months of continuous coverage from your prior carrier
   b. If your prior carrier has not provided you with a certificate, other examples of proof of prior coverage can include:
      - Explanation of benefits or other correspondence from a plan or issuer indicating coverage
      - Pay stubs showing a payroll deduction for health coverage
      - Health insurance identification card
      - Certificate of coverage for group health policy
6. **Proof of creditable coverage to reduce pre-existing waiting period: (if applicable)**
   a. Copy of a Certificate of Creditable Coverage showing the number of days of continuous coverage from your prior carrier
   b. If your prior carrier has not provided you with a certificate, other examples of proof of prior coverage can include:
      - Explanation of benefits or other correspondence from a plan or issuer indicating coverage
      - Pay stubs showing a payroll deduction for health coverage
      - Health insurance identification card
      - Certificate of coverage for group health policy
7. **Proof of Health Coverage Tax Credit (TAA or ATAA) or Pension Benefit Guaranty Corporation: (if you answered "Yes" to question II.5)**
   a. Completed Supplemental TAA form
   b. Copy of one of the following
      - TAA Certification
      - Health Coverage Tax Credit Certificate
      - Proof of Pension Benefit Guaranty Corporation
8. **Proof of Eligibility: (If you checked one of the responses in question II.11)**
   a. Letter from an individual health insurer that includes one of the following:
      - Denial or rejection letter due to a medical condition from health insurer
      - A conditional rider that would exclude coverage for a medical condition
      - A premium rate that exceeds the rate you would be charged (see "How much does it cost" at www.inclusivehealth.org or call 1-866 665-2117 to confirm the rate) by Inclusive Health
9. **Other documentation: (if applicable)**
   a. Disability Award Letter
   b. COBRA or state continuation coverage termination letter including reason for termination
   c. A copy of your COBRA Initial Election documents, a COBRA or state continuation premium bill or a letter from your former employer showing the individual COBRA or state continuation premium.
   d. Pre-existing condition waiting period letter from health carrier indicating when pre-existing condition limitation no longer applies to you
   e. Health Savings Account Banking Set-up form, if using HSA Banking option through Inclusive Health Plan
   f. Letter from employer of applicant, spouse or guardian verifying coverage is not available

Mail Application, payment and required documentation to:

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

****END OF APPLICATION****