INCLUSIVE HEALTH

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

Please mail or forward application to:
Inclusive Health
P.O. Box 30909
Raleigh, NC 27622

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
Date: (Provide Date when widowed, separated or 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. Are you a resident of the state of North Carolina? ☐ (Yes, less than 30 days) ☐ (Yes, more than 30 days) ☐ No
   Please provide a photocopy of current drivers license or state ID and one of the following: current 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)
2. Do you have legal resident status in the United States? ☐ Yes ☐ No
   Please provide a photocopy your Social Security card, birth certificate, passport, naturalization/citizenship certificate, unexpired Visa, unexpired I-94 card or green card. If green card is pending, you will need to supply a photocopy of your Employment Authorization Document (EAD) and Advance Parole (temporary travel document).
3. 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 (mini-COBRA) , and all of the following statements are true, you may qualify as a Federally Eligible HIPAA individual. *If you still have COBRA or state continuation coverage (mini-COBRA), it must be exhausted before your Inclusive Health coverage will start;*
   - 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 (mini-COBRA) 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;
   - 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.

(continued on next page)

SECTION II: ELIGIBILITY INFORMATION (continued)

4. Are you and 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

5. 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
6. Have you terminated Inclusive Health coverage within the last 12 months? (this question does not apply to you if you answered "Yes" to question 3 or 4)? ☐ Yes ☐ No
7. Are you an inmate or resident of a public institution? ☐ Yes ☐ No
8. Are you eligible for or enrolled in either Medicare Part A or Part B? ☐ Yes ☐ No
9. Are you eligible for or enrolled in the State Medical Assistance Plan or Medicaid? ☐ Yes ☐ No

   If you answered "No" to questions 3 and 4 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 Incusive Health in one of the eligibility categories below. If you answered "Yes" to question 3 or 4 skip to Section III below.

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

    ☐ **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.

    ☐ **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.

    ☐ **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.

    ☐ **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. You must include a letter from your physician confirming the diagnosis date.

- ☐ **AIDS/HIV**
- ☐ **Alzheimer's Disease**
- ☐ **Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)**
- ☐ **Aneurysm**
- ☐ **Angina Pectoris**
- ☐ **Angioplasty**
- ☐ **Ankylosing Spondylitis**
- ☐ **Cancer(except skin) treated or diagnosed in past 5 years**
- ☐ **Cardiomyopathy**
- ☐ **Cerebral Palsy**
- ☐ **Chronic Obstructive Pulmonary Disease**
- ☐ **Chronic Renal Failure**
- ☐ **Cirrhosis of the Liver**
- ☐ **Congestive Heart Failure**
- ☐ **Coronary Insufficiency**
- ☐ **Coronary Occlusion**
- ☐ **Crohn's Disease**
- ☐ **Cystic Fibrosis**
- ☐ **Emphysema**
- ☐ **Hemochromatosis**
- ☐ **Hemophilia**
- ☐ **Hepatitis C**
- ☐ **Hodgkin's Disease**
- ☐ **Huntington's Chorea**
- ☐ **Hydrocephalus**
- ☐ **Leukemia**
- ☐ **Lupus Erythematosus Disseminate**
- ☐ **Major Organ Transplant**
- ☐ **Multiple or Disseminated Sclerosis**
- ☐ **Muscular Dystrophy**
- ☐ **Myasthenia Gravis**
- ☐ **Myocardial Infarction**
- ☐ **Paget's Disease**
- ☐ **Paraplegia or Quadriplegia**
- ☐ **Parkinson's Disease**
- ☐ **Polyarteritis(periarteritis nodosa)**
- ☐ **Psoriatic Arthritis**
- ☐ **Psychotic Disease**
- ☐ **Raynaud's Disease**
- ☐ **Rheumatoid Arthritis**
- ☐ **Schizophrenia**
- ☐ **Stroke(CVA)**
- ☐ **Suicide Attempt**
- ☐ **Tetralogy of Fallot**
- ☐ **Ulcerative Colitis**

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 the 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 mini-COBRA benefits? ☐Yes ☐No

Are you enrolled in a COBRA or mini-COBRA plan through this employer? ☐Yes ☐No

If yes, what is the effective date of COBRA/mini-COBRA coverage? From: _____ To: _____

If no, indicate reason why you did not elect COBRA/mini-COBRA coverage:

_____

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 mini-COBRA benefits? ☐Yes ☐No

Are you enrolled in this plan under COBRA or mini-COBRA? ☐Yes ☐No

If yes, what is the effective date of COBRA/mini-COBRA coverage? From: _____ To: _____

If no, indicate reason why you did not elect COBRA/mini-COBRA coverage:

_____

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 the when it no longer applies to you.

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SECTION III: OTHER INSURANCE INFORMATION (continued)

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 mini-COBRA benefits? ☐Yes ☐No

Are you enrolled in a COBRA or mini-COBRA plan through this employer? ☐Yes ☐No

If yes, what is the effective date of COBRA/mini-COBRA coverage? From: _____ To: _____

If no, indicate reason why you did not elect COBRA/mini-COBRA coverage:

_____

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 mini-COBRA benefits? ☐Yes ☐No

Are you enrolled in this plan under COBRA or mini-COBRA? ☐Yes ☐No

If yes, what is the effective date of COBRA/mini-COBRA coverage? From: _____ To: _____

If no, indicate reason why you did not elect COBRA/mini-COBRA coverage:

_____

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 (mini-COBRA) 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.

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. Individuals enrolling in Inclusive Health by December 31, 2009 shall be subject to a six month pre-existing condition waiting period. All other individuals enrolling in Inclusive Health shall be subject to a twelve 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.3
- A TAA, ATAA or PBGC eligible individual (If you answered "Yes" to question II.4)
- 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.

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

SECTION IV: INFORMATION ABOUT YOUR HEALTH (continued)

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:

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 (available 1/1/2010).
   - ☐ 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 be not be setting up a Health Savings Account

Requested Effective Date:_____

Complete applications, including all documentation and the first month's premium, 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 (mini-COBRA). 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 first month's premium, 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)
The first month's premium must be submitted in the form of a personal check or money order with this application.
(Does not apply to TAA or ATAA individuals who answered "Yes" to question II.4)

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SECTION V: COVERAGE & PAYMENT OPTIONS (continued)

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.

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

If a North Carolina licensed insurance agent informed you about the insurance coverage provided by Inclusive Health, Inclusive Health will reimburse the agent $100 following Inclusive Health's approval of the application and receipt of the first premium payment.

Agent Name: _____

Agent LicenseNo. _____ 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 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. If I am exhausting COBRA or state continuation coverage (mini-COBRA), my coverage will not be 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 has been received and processed.
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.

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SECTION VII: DISCLOSURE AUTHORIZATION AND DECLARATION (continued)

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 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):**
   a. Did you include your premium payment with your application?
   (Does not apply to TAA or ATAA individuals who answered "Yes" to question II.4).
   b. Did you complete the bank withdrawal form and submit a voided check?
   c. Did you make your check payable to Inclusive Health?
3. **Proof of North Carolina Residency*:**
   a. Copy of current drivers license or state ID, plus
   b. One of the following:
      - current rent or mortgage payment receipt
      - voter registration card
      - state income tax return
      - property tax receipt
      - utility bill

      * Please note, the information provided in Section I must match the information on the proof of residency documents provided. If the rent/mortgage or utility bill is in a spouse's or guardian's name, a birth certificate or marriage certificate is also required.
4. **Proof of U S citizenship or Lawful Permanent Resident Alien**
   a. One of the following:
      - social security card
      - birth certificate
      - passport
      - naturalization/citizenship certificate
      - green card
   b. Pending green card (supply two documents)
      - Employment Authorization Document(EAD)
      - Advance Parole(temporary travel document)
5. **Proof of Federally Eligible HIPAA individual: (if you answered "Yes" to question II.3)**
   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

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SECTION VIII: APPLICATION REQUIREMENTS CHECKLIST (continued)

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.4)

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.10)

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 charges (see "How much does it cost" at www.inclusivehealth.org or call 1-866-665-2117 to confirm the rate) by Inclusive Health
- Letter from your physician confirming diagnosis date for each one of the medical conditions listed in question II.10

9. Other documentation: (if applicable)

a. Disability Award Letter

b. COBRA or state continuation coverage (mini-COBRA) termination letter including reason for termination

c. Pre-existing condition waiting period letter from health carrier indicating when pre-existing condition limitation no longer applies to you

d. Health Savings Account Banking Set-up form, if using HSA Banking option through Inclusive Health Plan

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
P.O. Box 30909
Raleigh, NC 27622

Do you need help with your premium? Check out Inclusive Health's Subsidy Program. We can offer assistance to people who qualify based on income and family size. Visit our website at: www.inclusivehealth.org or call (866) 665-2117 to learn more.

****END OF APPLICATION****