Dear Prospective Applicant:

Thank you for requesting information regarding health insurance coverage from the Texas Health Insurance Risk Pool. The Texas Health Insurance Risk Pool is an entity created by Texas law to provide health insurance to Texans who meet certain specific requirements. Due to these requirements, the application is detailed, with certain personal and medical information and documentation to be provided for each applicant. If you need assistance in completing the application or providing the necessary documentation, please contact our customer service representatives at 1-888-398-3927 or visit our web site at www.txhealthpool.org. Enclosed are the following materials:

1. **Outline of Coverage –** Describes the health insurance coverage available through the Texas Health Insurance Risk Pool. Please read the Outline very carefully, particularly the sections dealing with deductibles, coinsurance, and the Pool's pre-existing condition limitation, which applies to medical and prescription claims.

2. **Application for Coverage**

3. **Employment Information Form(s)**

4. **Checklist –** Review and check off each item on the Checklist before returning it with your application.

IMPORTANT NOTICE: If you or your dependents were covered by prior group coverage, you and your dependents may be eligible for COBRA or state continuation of coverage. If an individual is eligible for COBRA or state continuation, the individual is not eligible for Pool coverage until the scheduled termination date of such continuation coverage, even if the continuation coverage was not elected by the individual. Please note: a dependent, covered under the terminating prior group coverage, is entitled to continuation, regardless of the continuation election of the employee. If you are eligible for COBRA or continuation, you need to elect that coverage within your election period. Pool applications are accepted up to 60 days prior to the scheduled COBRA or continuation termination date.

If you are interested in applying for coverage, please complete and return the application for coverage and the employment information form(s) with your premium payment to the appropriate address shown below. **Be sure you select your correct premium amount from the rate tables provided or shown on the "Rates" page of the Pool's web site. If you are entitled to benefits under Medicare, be sure to refer to the MEDICARE-ELIGIBLE premium rate table.**

Regular Mail Only:

Texas Health Insurance Risk Pool
P. O. Box 6089
Abilene, TX 79608-6089

Overnight Delivery Only:

Texas Health Insurance Risk Pool
4002 Loop 322
Abilene, TX 79602

The effective date of coverage will be the first day of the month following the date your complete application is approved, unless you request a later date. If we are unable to approve your application, you will be notified promptly by mail. Incomplete applications will delay processing and your coverage effective date. Please allow adequate processing time.

Thank you for your interest in coverage with the Texas Health Insurance Risk Pool.

Sincerely,

Customer Service
Texas Health Insurance Risk Pool

OUTLINE OF COVERAGE
Individual Major Medical Coverage

Policy and Medical Claims Administered By:	**Blue Cross and Blue Shield of Texas***
Address:	**P. O. Box 6089, Abilene, TX 79608-6089**
Toll Free Number:	**1-888-398-3927**
	(Administrator)
Pharmacy Program Administered By:	**Medco Health Solutions, Inc.**
Address:	**100 Parsons Pond Drive**
	Franklin Lakes, NJ 07147
Toll Free Number:	**1-800-290-1708**
	(Pharmacy Manager)

The Texas Health Insurance Risk Pool (the Pool) was created by the Texas legislature to offer health insurance to residents of the state through participation of health insurance companies. This program is designed to provide health insurance to those Texas residents who are unable to obtain adequate health coverage due to their medical condition or who are considered Federally Eligible Individuals as defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

I. **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of Your Policy. This is not the insurance policy and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and the Pool. It is, therefore, important that You **READ YOUR POLICY CAREFULLY! Your application and Your acceptance of the Policy, if issued, constitute Your agreement to the terms and limitations of the Policy.**

II. This Policy is designed to provide eligible individuals with coverage for major hospital, medical, and surgical expenses, incurred as the result of a covered injury or sickness. Only eligible individuals and their Dependents and Family Members are eligible for coverage by the Pool.

A. Eligibility for Coverage

1. You are eligible for coverage by the Pool if You are under age 65 and You are and remain a legal resident of Texas and You provide evidence that You have maintained Health Insurance coverage for the 18 months preceding Your application for coverage to the Pool, with no gap in coverage greater than 63 days, provided the last Health Insurance was through an employer sponsored plan, church plan, government plan or another state's high risk pool.
2. You are eligible for coverage by the Pool if You are under the age of 65 (or over the age of 65 and not enrolled in Medicare Part B), and remain a legal resident of Texas and You provide evidence that You are certified as eligible under Trade Adjustment Assistance or the Pension Benefit Guaranty Corporation (collectively, the HCTC Program).
3. You are also an eligible individual if You are under age 65, have been for at least 30 days and remain a legal resident of Texas and a United States citizen or a permanent legal resident of the United States for at least three continuous years, and You provide evidence to the Pool’s Administrator of one of the following:
   a. A notice of rejection or refusal by an Insurance Company to issue substantially similar individual Health Insurance to You for health reasons;
   b. A certification from an agent or salaried representative of an Insurance Company, on the Pool’s Application form, that states the agent or representative is unable to obtain substantially similar individual Health insurance for You with any state-licensed Insurance Company, which the agent or representative represents, because You will be declined for coverage, as a result of Your medical condition, under the underwriting guidelines of the Insurance Company;

*A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

c. An offer by an Insurance Company to issue substantially similar individual Health Insurance to You only with conditional riders, which exclude coverage for medical conditions; or

d. You have been diagnosed with one of the following medical conditions, determined as a condition for automatic eligibility by the Pool Board of Directors:

- Cancer
  - Malignant Tumor within 4 years (except skin cancer)
  - Metastatic
- Cardiovascular
  - Artificial Heart Valve
  - Cardiomyopathy
  - Coronary Artery Disease
  - Polyarteritis Nodosa
  - Peripheral Vascular Disease, including Intermittent Claudication
- Endocrine/Exocrine
  - Diabetes Mellitus
  - Cystic Fibrosis
  - Addison's Disease
- Gastrointestinal
  - Intestinal
    - Crohn's Disease
    - Ulcerative Colitis
  - Liver
    - Cirrhosis (non-alcoholic)
    - Wilson's Disease
    - Hepatitis
- Hematopoietic
  - Anemia
    - Sickle Cell
    - Splenic (True Banti's Syndrome)
  - Hemophilia
  - Leukemia
  - Thalassemia
- Hodgkin's Disease
- Immunological
  - Acquired Immune Deficiency Syndrome (AIDS) or HIV Positive
  - Lupus
- Musculoskeletal
  - Dermatomyositis or Polymyositis
  - Muscular Atrophy or Dystrophy
  - Myotonia
  - Rheumatoid Arthritis
  - Still's Disease
  - Legge-Perthes Disease (Waldenstrom's Disease)
- Neurological – Central Nervous System
  - Cerebral Palsy
  - Cerebral Vascular Accident (CVA)
  - Epilepsy
  - Huntington's Chorea
  - Hydrocephalus
  - Lead Poisoning with Cerebral Involvement
  - Lobotomy
  - Parkinson's Disease (if treatment within last 3 years)
  - Guillian-Barre Syndrome
- Neurological – Peripheral Nervous System (including Spinal Cord)
  - Amyotrophic Lateral Sclerosis (ALS)
  - Friedrich's Ataxia
  - Myasthenia Gravis
  - Paraplegia or Quadriplegia
  - Sclerosis, Multiple, Disseminated or Postero-lateral
  - Syringomyelia
  - Tabes Dorsalis (Locomotor Ataxia)
- Psychiatric
  - Psychotic Disorders
- Pulmonary
  - Silicosis (Black Lung)
- Renal
  - Polycystic Kidney
- Other
  - Brain Tumor
  - Down's Syndrome
  - Scleroderma
  - Transplants
    - Heart
    - Kidney
    - Liver
    - Lung

4. Dependents: Your Dependents are also eligible for coverage by the Pool. If the eligible individual is a child, Family Members of the child who have been for at least 30 days and remain legal residents of Texas and United States citizens and who reside with the child are also eligible for coverage by the Pool.

B. Persons Not Eligible

Even if You meet an eligibility requirement above, You are not eligible for coverage by the Pool if You:

1. Have other Health Insurance in effect on the date Pool coverage would otherwise be effective (This does not apply to eligibility under the HCTC Program. In the case of coverage by Medicare, You are allowed to retain Medicare coverage if You otherwise qualify for the Pool. The Pool's coverage will be secondary to coverage provided by Medicare.);
2. Are eligible for or covered by employer-sponsored Health Insurance, including a self-insured health benefit plan or continuation of coverage under state or federal law (If You are or were eligible for COBRA or state mandated continuation, You are not eligible for Pool coverage until the scheduled termination of such continuation, even if You do not elect the continued coverage); except:
   a. coverage, continued under state or federal law, maintained for the period of time necessary to satisfy any Preexisting Condition limitation period for Pool coverage (does not apply to eligibility under the HCTC Program); or
   b. an employer group plan, church plan or government coverage that either excludes an individual or limits coverage for an individual by conditional riders; a pre-existing condition limitation of a benefit plan does not constitute an exclusion or a conditional rider of an individual or an individual's medical condition (does not apply to eligibility under the HCTC Program).

   Note: If You or Your dependents were covered by prior group coverage, You and Your dependents may be eligible for COBRA or state continuation of coverage. If an individual is eligible for COBRA or state-mandated continuation, the individual is not eligible for Pool coverage until the scheduled termination of such continuation coverage, even if the continuation coverage was not elected by the individual. A dependent, covered under the terminating prior group coverage, is entitled to continuation, regardless of the continuation election of the employee.
3. Are covered by individual Health Insurance, unless You cancel or lapse such other coverage within 60 days after the effective date of Pool coverage. If such other individual Health Insurance coverage limits coverage for an individual by excluding one or more medical conditions, such other coverage may be continued while the Pool coverage is in force. During any period other individual Health Insurance coverage is in effect, after the effective date of Your Pool coverage, the Pool coverage will be secondary to such other coverage.
4. Have terminated coverage through the Pool within the twelve months preceding Your application for coverage by the Pool, unless You demonstrate a good faith reason for the termination;
5. Are confined to a county jail or imprisoned in a state or federal prison;
6. Have premiums paid or reimbursed by or under any government sponsored program or any government agency or health care provider, unless You qualify as a full-time employee or such employee's dependent of such government agency or health care provider (does not apply to eligibility under the HCTC Program);
7. Had prior coverage by the Pool that was terminated for nonpayment of premiums within the twelve months preceding Your application for coverage by the Pool;
8. Had prior coverage by the Pool that was terminated for fraud; or
9. Have received $1,500,000 in benefits from the Pool under this Policy, including the benefits paid under any other Pool policies.

III. Benefits

A. The benefits outlined in the table below show the payment percentages for Covered Expenses AFTER each Insured Person has satisfied any deductibles. You have a choice of three plans of coverage. Plan I has a $1000 Calendar Year Deductible; Plan II has a $2500 Calendar Year Deductible; and Plan III has a $5,000 Calendar Year Deductible. The Calendar Year Deductible amount selected may not be changed to a lower amount after the Policy is issued. You may request to change to a higher Calendar Year Deductible, if offered by the Pool, but only one such change will be allowed in a calendar year. The change will be effective on the first of the month following the date the Pool receives Your written request for such change or a later date, if You request it.

Covered Expenses are limited to the Allowable Amount determined by the Administrator. For a Preferred Provider, the Allowable Amount is based on the terms of the Preferred Provider network contract and the payment methodology in force on the date of service. The payment methodology used may include diagnosis-related groups (DRGs), relative value, resource based relative value scale (RBRVS), fee schedules, package pricing, global pricing or other payment methodologies. For a Non-Preferred Provider, the Allowable Amount is based on the amount that would have been paid for the same covered service, supply or procedure with an equivalent Preferred Provider.

IMPORTANT: All claim payments are based on Allowable Amounts. Preferred Providers, contracted with the Administrator, must accept these Allowable Amounts as payment in full, subject to the deductibles and Preferred Provider Coinsurance Percentage. If an Insured Person uses a Non-Preferred Provider, the Insured Person will be responsible for charges over the Allowable Amount, in addition to the deductibles and the Insured Person's share of the Non-Preferred Provider Coinsurance Percentage. ParPlan Providers have agreed to accept the Allowable Amount as payment in full, subject to the Insured Person's payment of the deductibles and the Insured Person's share of the Non-Preferred Provider Coinsurance Percentage.

Even if You consult a Preferred Provider, ask about any of the providers rendering care to You. For example, if You are scheduled for surgery, ensure that Your Preferred Provider surgeon will be using a Preferred Provider facility for Your procedure and a Preferred Provider for Your anesthesia, radiology or pathology services.

Services You receive during an inpatient or outpatient admission may include care rendered by hospital-based, ancillary Non-Preferred Providers, such as an anesthesiologist, pathologist, radiologist, neonatologist or emergency medicine physician. To confirm if Your Preferred Provider facility includes ancillary Preferred Providers, go to "Provider Finder" at http://www.bcbstx.com/onlinedirectory/ppo.htm and, in the Custom Search box, click on the link at the "Important Note" to verify information for Your facility.

After each Insured Person has paid the applicable deductibles, the Policy will pay the amount of Covered Expenses in excess of the coinsurance amount. For Covered Expenses from a Preferred Provider, once You have paid Your Coinsurance Maximum, the Policy will pay 100% of Covered Expenses from Preferred Providers for the remainder of the calendar year. There is no Coinsurance Maximum for Covered Expenses from a Non-Preferred Provider, including ParPlan Providers. The Policy will never pay 100% for Covered Expenses from a Non-Preferred Provider. In no event will the Policy pay more than the Lifetime Maximum for each Insured Person. Also, the Calendar Year Deductible, the emergency care deductible, physician office visit copayments and charges for outpatient prescription drugs, including charges applied to the prescription drug deductible or copayments, do not count toward the Coinsurance Maximum.

The Calendar Year Deductible and Coinsurance Maximum are accumulated on a calendar year basis, regardless of when Your coverage becomes effective. However, Covered Expenses, which are applied toward the Calendar Year Deductible in the last three months of the year, will also be applied in an equal amount to the Calendar Year Deductible for the next year.

Covered Expenses are charges for services and supplies, which are covered by the Policy, that are not in excess of Allowable Amounts and that are determined by the Administrator to be Medically Necessary for treatment of an illness or injury.

Lifetime Maximum or Lifetime Maximum Amount means the maximum amount of covered expenses payable by the Pool under this Policy and any other Pool policy for each Insured Person. The Lifetime Maximum Amount is $1,500,000.

WHAT YOU PAY	**PLAN I**	**PLAN II**	**PLAN III**
Calendar Year Deductible for each Insured Person	$1000	$2500	$5000
Coinsurance for PPO Providers	20%	20%	20%
Coinsurance for Non PPO Providers	40%	40%	40%
Coinsurance Maximum for PPO Providers (calendar year) for each Insured Person	$3000	$3000	$3000
Coinsurance Maximum for Non PPO Providers (calendar year) for each Insured Person	None	None	None
Lifetime Maximum Amount for each Insured Person	$1,500,000		

BENEFITS

Hospital	Average semi-private room rate No more than one visit per physician per day
Intensive Care or Cardiac Care Unit	No more than 3 times the average semi-private room rate
Assistant surgeon or Surgical First Assistant	One assistant, no more than 25% of the primary surgeon's fee
Hospital or other facility for Emergency Care	Subject to additional $75 deductible per visit
Physician Office Visit (**Preferred Providers Only**)	$30 copayment per visit, 3 visits per calendar year Visits after first 3, subject to Calendar Year Deductible & Coinsurance
Therapy, including Physical, Occupational & Speech Language Therapy	Combined maximum benefit of $2,000 per calendar year

Skilled Nursing Facility	45 days per calendar year
Home Health Care	Calendar year maximum benefit of lesser of 60 visits or $5,000
Hospice Care	Lifetime maximum benefit of lesser of 180 days or $10,000
Ambulance	Calendar year maximum benefits of $2,000 ground & $5,000 air
Named Transplants	$300,000 combined lifetime maximum benefit
Serious Mental Illness	Calendar year maximum benefit of 30 inpatient days and 50 outpatient visits
Preauthorization Provisions	If a preauthorization requirement is not met, benefits for covered expenses will be reduced 50%

Other Benefits (see Policy for specific benefits)

- Acquired brain injury
- Allergy tests and injections
- Anesthesia
- Blood
- Breast reconstruction in connection with mastectomy
- Colorectal screening
- Complications of Pregnancy (no coverage for normal maternity)
- Diabetes equipment, supplies and self-management training
- Dietary formulas for PKU and other heritable diseases
- Durable medical equipment
- Genetic Testing and Counseling
- Growth Hormone Treatment
- Home infusion therapy
- Miscellaneous Hospital services and supplies
- Outpatient care
- Outpatient contraceptive services
- Oxygen
- Preadmission Testing
- Preventive Care
- Prosthetic devices
- Radiation therapy, inhalation therapy, chemotherapy
- Reconstructive Surgery
- Reduction Mammoplasty
- Second Surgical Opinion
- Surgeons
- Surgical services and supplies from an Ambulatory Surgical Center and Hospital outpatient facility
- X-rays and laboratory tests
- Vasectomy and tubal ligation or occlusion

B. Preauthorization and Case Management Provisions

The special features listed below allow You access to the medical care You need, while they reduce the costs to You and the Pool.

1. Preauthorization: Information is reviewed by medical personnel to authorize specific services. Preauthorization is required for the following medical services: inpatient hospital admissions, skilled nursing facility admissions, home health care services, home infusion therapy, hospice care, durable medical equipment over $2,000 and organ and tissue transplants. It is necessary to contact the Administrator prior to obtaining such services. **If the service is not preauthorized, the benefit for the service will be reduced by 50%.** In addition, certain benefits administered by the Pharmacy Manager are subject to Prior Authorization. Please see the Prescription Drug benefit description for details.
2. Case management: The case manager will work with You and Your physician to determine the appropriate level of care You need.

C. BlueChoice® Network

The Pool has selected the BlueChoice® Network as the Pool's Preferred Provider Organization (PPO). Although You may choose any medical provider or hospital, You will save money by using providers from the BlueChoice® Network.

If You choose a BlueChoice provider, the Policy will pay a greater coinsurance rate and the BlueChoice provider's rate will be based on the Allowable Amount for that provider's service. If You choose a medical provider or hospital not participating in the BlueChoice® Network, the Policy will pay a lower coinsurance rate for covered expenses and there is no Coinsurance Maximum for covered expenses from Non-Preferred Providers, including ParPlan Providers. Also, Covered Expenses of Non-Preferred Providers, paid by the Policy, will be based on the Allowable Amount, determined by the Administrator, which may be less than the provider's billed rate. The provider may bill You for the difference between the charges paid by the Policy and the provider's billed rate (balance billing). If this occurs, You will have a greater out of pocket expense. If You choose a ParPlan Provider, the Policy will pay the Non-Preferred Provider level of benefits, but the ParPlan Provider has agreed to: file Your claims; not bill You for the difference between the ParPlan Provider's charge and the Allowable Amount covered under this Policy for any treatment or services; and not bill You for treatment or services that are not Medically Necessary, as determined by the Administrator.

There are other advantages to using BlueChoice providers. They will handle the initial paperwork so You do not have to file claims. They may also precertify benefits for You, although it is ultimately Your responsibility to ensure that Your services have been authorized by the Pool.

A list of Preferred Providers in Your area is contained in the Preferred Provider Directory that was provided to You. You may call the Administrator's precertification referral department at its toll free number, 1-888-398-3927, to obtain the name of a Preferred Provider outside Your area, if needed. Any changes to the list of Preferred Providers will be made available to You not less than annually. You may call the Administrator during regular business hours to receive a current list of Preferred Providers. The list of Preferred Providers changes from time to time so it is important for You to verify the network status of Your providers. You can do this by confirming with Your provider that the provider is a member of the network or by calling the Administrator or checking the list of current Preferred Providers found on the Pool's web site (www.txhealthpool.org).

If there are no BlueChoice providers available to You, You must contact the Administrator's precertification referral department at its toll free number. Generally, a BlueChoice provider will be considered to be unavailable to You if You reside more than 30 miles from a BlueChoice provider. If there are no BlueChoice providers available to You and You receive approval from the Administrator before obtaining services from a Non-Preferred Provider, Covered Expenses for treatment or services by the Non-Preferred Provider will be paid at the Preferred Provider coinsurance level. If You fail to obtain approval from the Administrator prior to obtaining the services of a Non-Preferred Provider, Covered Expenses for treatment or services by that Non-Preferred Provider will be paid at the Non-Preferred Provider Coinsurance Percentage, regardless of the availability to You of a Preferred Provider.

When an Insured Person receives covered Emergency Care Services from a Non-Preferred Provider, those services will be paid as if they were received from a Preferred Provider. However, once the Insured Person can be safely transferred to a Preferred Provider, the Insured Person must be transferred to a Preferred Provider in order to continue receiving the Preferred Provider level of benefits. If the Insured Person chooses not to transfer, Policy benefits will be payable at the lower Non-Preferred Provider level.

IMPORTANT: All claim payments are based on Allowable Amounts. Preferred Providers, contracted with the Administrator, must accept these Allowable Amounts as payment in full, subject to the deductibles and Preferred Provider Coinsurance Percentage. If an Insured Person uses a Non-Preferred Provider, the Insured Person will be responsible for charges over the Allowable Amount, in addition to the deductibles and the Insured Person's share of the Non-Preferred Provider Coinsurance Percentage. ParPlan Providers have agreed to accept the Allowable Amount as payment in full, subject to the Insured Person's payment of the deductibles and the Insured Person's share of the Non-Preferred Provider Coinsurance Percentage.

Even if You consult a Preferred Provider, ask about any of the providers rendering care to You. For example, if You are scheduled for surgery, ensure that Your Preferred Provider surgeon will be using a Preferred Provider facility for Your procedure and a Preferred Provider for Your anesthesia, radiology or pathology services

Services You receive during an inpatient or outpatient admission may include care rendered by hospital-based, ancillary Non-Preferred Providers, such as an anesthesiologist, pathologist, radiologist, neonatologist or emergency medicine physician. To confirm if Your Preferred Provider facility includes ancillary Preferred Providers, go to "Provider Finder" at http://www.bcbstx.com/onlinedirectory/ppo.htm and, in the Custom Search box, click on the link at the "Important Note" to verify information for Your facility.

If an Insured Person's Preferred Provider's arrangement with the Network, chosen by the Pool for this Policy, terminates and, at the time of such termination, the Insured Person has special circumstances, benefits for Covered Expenses received from that provider will be paid as if the Covered Expenses were received from a Preferred Provider until: in the case of an Insured Person who has been diagnosed with a terminal illness, the end of nine months after the effective date of termination; in the case of an Insured Person who, at the time of termination, is past the 24th week of pregnancy, delivery of the child, immediate post-partum care and the follow-up checkup within the first six weeks after the delivery; or in all other special circumstances, the end of 90 days after the date of termination.

"Special circumstances" means a condition such that the treating Physician reasonably believes that discontinuing care by the treating Physician could cause harm to the patient. Special circumstances must be identified by the treating Physician who must: make a request to the Administrator that the Insured Person be permitted to continue treatment under the Physician's care; and agree not to seek payment from the Insured Person for any amounts in excess of the Preferred Provider rate for the treatment or services rendered.

D. BlueCard Program

The BlueCard Program provides access to Preferred Providers of other Blue Cross and/or Blue Shield Plans outside Texas. If You incur expenses outside Texas through the BlueCard Program, You must pay the Preferred Provider Coinsurance amount, after satisfaction of the Deductible. Covered Expenses for a BlueCard program provider will be calculated using the lesser of the billed charges of the BlueCard Program provider or the negotiated rate the Administrator pays the local Blue Cross and/or Blue Shield Plan.

E. Pharmacy Benefits

This benefit does not apply to an Insured Person eligible for Medicare. The Pool offers a statewide network of pharmacies, a Mail Order program and a Specialty Medications program through Medco Health Solutions, Inc., the Pharmacy Manager. To ensure proper dosage and use, some prescription drugs may be subject to a quantity limit per prescription and/or per 30-day supply. Certain drugs will require prior authorization by the Pharmacy Manager before You can obtain a covered prescription drug at a network pharmacy. A list of the drugs, including growth hormone drugs and rheumatoid arthritis agents, that require prior authorization can be obtained on the Pool web site, www.txhealthpool.org, or by calling the Pharmacy Manager's toll free number shown on the first page of this Outline of Coverage. Compounded drugs and branded generic drugs will be covered as brand name drugs.

1. Prescription Drug Deductible

Benefits for outpatient prescription drugs are subject to a calendar year deductible of $100. Charges applied to this deductible or to the applicable drug Copayments do not apply to the Calendar Year Deductible or to the Coinsurance Maximum amount.

2. Pharmacy Network Benefits

When Your prescriptions are filled at a network pharmacy, for up to a 30-day supply, You will pay $10 for generic drugs, or, if a generic drug is not available, $25 for formulary brand name drugs or $40 for non-formulary brand name drugs. If a generic drug is available and You receive a brand name drug, You will pay the applicable brand name drug Copayment plus the difference in cost between the generic drug and the brand name drug.

The Pool also offers a Mail Order program through the Pharmacy Manager. When Your prescriptions are filled through the Mail Order program, for up to a 90-day supply, You will pay $25 for generic drugs, or if a generic drug is not available, $60 for formulary brand name drugs or $100 for non-formulary brand name drugs. If a generic drug is available and You receive a brand name drug, You will pay the applicable brand name drug Copayment plus the difference in cost between the generic drug and the brand name drug.

The Pool also offers a Specialty Medications program through the Pharmacy Manager for Insured Persons who are receiving treatment for complex disease states. Specialty medications, obtained through the program, will be subject to the Prescription Drug Deductible, if not met and the applicable network pharmacy Copayment and will not exceed a 30-day supply.

3. Non-Network Pharmacy Benefits

When You fill a prescription at a non-participating pharmacy, You must pay the charges of the pharmacy and submit a claim to the Pharmacy Manager. After deduction of the Prescription Drug Deductible, if not met, and the applicable Copayment, the Pharmacy Manager will pay a benefit equal to 90% of the lesser of the pharmacy's usual and customary charge or the amount that would have been paid by the Policy for the same prescription if dispensed by a network pharmacy. A covered prescription will not exceed a 30-day supply.

IV. Insured Person's Financial Responsibility

The Insured Person is financially responsible for: payment of premiums on a timely basis; payment to health care providers for charges that are applied to the calendar year deductible, Prescription Drug Deductible or emergency care deductible; payment to health care providers for the balance of charges after the Pool's payment of the Coinsurance Percentage; copayment amounts; balance of charges, if any, between Allowable Amounts and a Non-Preferred Provider's billed rate; any charges that are not a Covered Expenses payable under the Policy; any charges for services or treatment excluded under the Policy; and amounts in excess of benefit maximum amounts.

V. Subrogation and Reimbursement

The Pool has a right to subrogation and reimbursement, as outlined in the Policy and §§1506.301-1506.305, Texas Insurance Code.

VI. Right to Recover an Overpayment

If the Pool makes any overpayment, the Pool can recover what it did not owe from the person to whom the payment was made or from any other appropriate person. The Pool has this right even if the mistake was the Pool's fault. If the overpayment was made to You, the Pool has the right to deduct it when the Pool pays Your claims.

VII. Exclusions and Limitations

A. Preexisting Condition Limitation:
During the first 12 months following Your effective date of coverage, the Policy will not pay benefits for any charges or expenses for a Preexisting Condition. A Preexisting Condition is a disease or condition: for which the existence of symptoms would cause an ordinarily prudent person to seek diagnosis, care or treatment during the six month's before an Insured Person's effective date of coverage; or for which medical advice, care or treatment was recommended or received during the 6 months prior to an Insured Person's effective date of coverage. Preexisting Condition includes a preexisting pregnancy or a complication of a preexisting pregnancy, whether the complication occurs before or after the effective date of coverage. Preexisting Condition does not include genetic information, in the absence of a diagnosis of the condition related to the genetic information.

The Preexisting Condition limitation will not apply to an Insured Person who:

1. has maintained Health Insurance for the 18 months immediately preceding the Insured Person's application for coverage under this Policy, excluding any waiting period, with no gap in coverage greater than 63 days, provided the most recent coverage was through an employer-sponsored plan, church plan, government plan or another state's high risk pool; or
2. was continuously covered for an aggregate period of 12 months by Creditable Coverage that was in effect up to a date not more than 63 days before the Insured Person's effective date under this Policy, excluding any waiting period, provided that application for coverage under this Policy is made no later than 63 days following the termination of such Creditable Coverage; or
3. who has been continuously covered, since birth, adoption or Your suit for adoption of the Insured Person, by Creditable Coverage that was in effect up to a date not more than 63 days before the Insured Person's effective date under this Policy, excluding any waiting period, provided that application for coverage under this Policy for the Insured Person is made no later than 63 days following the termination of such Creditable Coverage.

The Preexisting Condition limitation will not apply if You are eligible for Pool coverage under the HCTC Program and You were continuously covered for an aggregate period of 3 months of Creditable Coverage that was in effect up to a date not more than 63 days before Your effective date under this Policy, excluding any waiting period, provided that application for coverage under this Policy is made no later than 63 days following the termination of such Creditable Coverage.

In determining whether the Preexisting Condition limitation applies to You, credit will be given for the time You were covered under any prior Creditable Coverage, including any waiting period for that coverage, that was in effect at any time during the 12 months before Your effective date under this Policy.

B. The Policy will not pay benefits for services or expenses or any loss resulting from or in connection with:

- Services, supplies or treatment provided: prior to the Effective Date of coverage or after the termination date of coverage for an Insured Person; or for the portion of any Hospital or other inpatient facility admission that occurs before the Effective Date of coverage or after the termination date of coverage for an Insured Person.
- Any service or supply that is not medically necessary.
- Charges for treatment, services or supplies that are Experimental or Investigational in nature.
- Any expense determined by the Pool to be in excess of the Allowable Amount.
- Any penalty or fee for the failure to keep a scheduled visit with a Physician; or any charges for completion of any insurance forms or for acquisition of medical records.
- Any charge for services or supplies that are not within the scope of authorized practice of the institution or person rendering the services or supplies.
- Any charges for physical therapy, occupational therapy or speech language therapy provided by an educational institution or school district.
- Elective procedures, treatments or medications therefor, including but not limited to, abortions, sterilization reversals, sexual transformations, sexual dysfunctions, sexual inadequacies or disorders, or treatment for impotence.
- Any treatment provided by an Immediate Family Member of an Insured Person, except as provided for diabetes self-management training.
- Any loss to which a contributing cause was the Insured Person's being engaged in an illegal occupation or activity, or commission of or attempt to commit a felony.
- War or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion.

- Injury or Sickness, regardless of cause, if charges are incurred while serving in the armed forces or auxiliary units. Premium will be refunded on a pro rata basis for any Insured Person who enters military service; all coverage for that person will be suspended until military service is over.
- Any loss for which Worker's Compensation or Employer's Liability or Occupational Disease Benefits are payable.
- Cosmetic or reconstructive surgery, except as provided in the Benefits Provisions. Surgery performed to treat a mental, emotional or nervous disorder through change in appearance is considered a cosmetic surgery for purposes of this exclusion.
- Bariatric surgical procedures or complications related to such surgeries, even if the Insured Person has other health conditions that are related to, caused by or impacted by excess weight, obesity or morbid obesity, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
- Aviation of any type, except for an air ambulance when medically necessary or as a passenger on a regularly scheduled flight on a commercial airline.
- Charges incurred outside the United States if the Insured Person traveled to the location for the purposes of receiving medical services, drugs or supplies.
- Care received in Veterans Administration Hospitals or facilities for a service-connected disability.
- Services or treatment provided in a government hospital unless there is a legal obligation to pay in the absence of insurance. This does not exclude coverage for the treatment of mental health and mental retardation provided by a tax supported institution of the state of Texas, including community centers for mental health and mental retardation services, provided charges are regularly and customarily charged to non-indigent patients and if benefits under this Policy would otherwise be provided.
- Services or treatment for which the Insured Person is not legally required to pay, except Medicaid.
- Personal items such as TV, admitting kits, cots for Immediate Family Members, guest meals and other items that are not Medically Necessary.
- Any dental services or supplies except as necessitated by accidental Injury. Covered Expenses must be incurred within 12 months of the date of Injury. Injuries caused by chewing or biting down are excluded.
- Eyeglasses, contact lenses, hearing aids or the examination for prescription or fitting thereof, radial keratotomy or any eye surgery solely for the purpose of correcting refractive defects; treatment of myopia and other errors of refraction; orthoptics or visual training.
- Alcoholism or drug addiction.
- Any service or supply to eliminate or reduce a dependency on or addiction to tobacco or a controlled substance.
- Overdose of or illness or injury resulting from use of drugs, narcotics, hallucinogens, controlled or uncontrolled substances, unless administered on and according to the advice of a Physician.
- Illness or Injury to which a contributing cause was the Insured Person's being under the influence of or resulting from the use of intoxicants, including but not limited to, alcoholic pancreatitis, alcoholic hepatitis or alcoholic cirrhosis of the liver.
- Any service or supply associated with an autopsy or postmortem examination unless requested by Us.
- Private duty nursing services, except as provided in the Home Health Care benefit in the Benefits Provisions.
- Any service or supply in connection with the diagnosis or treatment of infertility, male or female, and any form or attempt of artificial fertilization or implantation, including artificial insemination, in-vitro fertilization, and gamete intra-fallopian transfer.
- Augmentation or reduction mammoplasty, except as provided in the Benefits Provisions, or removal of prosthetic devices, except in the case of cancer.
- Room and board charges incurred during a Hospital admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Insured Person's physical condition or the quality of medical care provided.
- Charges incurred in connection with a Hospital or other inpatient stay primarily for environmental change, physical therapy, custodial care or rest cures.
- Transportation, except as provided for ambulance services in the Miscellaneous Services benefit in the Benefits Provisions.
- Any service or supply for the diagnosis or treatment of temporomandibular joint dysfunction, unless due to accidental Injury.
- Any service or supply received by an Insured Person as a result of or in connection with a court order, except a medical support order requiring coverage for a dependent child.
- Any service or supply in connection with routine foot care, including the removal of warts, corns or calluses, the cutting and trimming of toenails, or foot care for flat feet, fallen arches, chronic foot strain, or symptomatic complaints of the feet in the absence of severe systemic disease; or any arch supports, orthopedic shoes or support hose, or similar type devices/appliances regardless of intended use, unless such use is for prevention of amputation in connection with treatment of diabetes.
- Any occupational therapy services that do not consist of traditional physical therapy modalities and that are not part of any active multi-disciplinary physical rehabilitation program designed to restore lost or impaired bodily function.
- Any medical social services or vocational counseling.
- Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

- Confinement or treatment in any convalescent home, sanitarium, convalescent rest or nursing facilities or facilities primarily affording custodial or educational care or facilities for the aged, except as specifically provided in the Skilled Nursing Facility benefit in the Benefits Provisions.
- Any service or supply used for preventive care, except preventive care provided for chronic illness, cancer or HIV/AIDS or as specifically provided in the Benefits Provisions.
- Any service or supply provided for inpatient or outpatient mental health, except as specifically provided for treatment of Serious Mental Illness in the Benefits Provisions.
- Any service or supply provided for prescription drugs, except as specifically provided in the Benefits Provisions.
- Nutritional counseling or food supplements, except as provided for Home Infusion Therapy or treatment of Phenylketonuria (PKU) or other heritable diseases in the Benefits Provisions.
- Growth hormone drugs or treatments, except as provided in the Benefits Provisions.
- Any services for transplants or replacements, except as specifically provided in the Benefits Provisions.
- Genetic testing or counseling, except as provided in the Benefits Provisions, biofeedback, travel expenses, holistic therapies, acupuncture, hypnosis or massage therapy.
- Any services, supplies or medications used for the primary purpose of evaluation for or diagnosis or treatment of the condition known as Idiopathic Environmental Intolerance (IEI) or Multiple Chemical Sensitivities (MCS) or Environmental Sensitivities (ES) or any other term by which these conditions may be known.
- Charges for pregnancy or maternity care, including but not limited to normal deliveries, elective caesarean sections and elective abortions, except as provided for Complications of Pregnancy

C. In addition to those exclusions, Covered Expenses under the Prescription Drug benefit for prescription drugs will not include charges for:

- Outpatient prescription drugs and medicines, devices, equipment and supplies of any kind provided to an Insured Person eligible for Medicare.
- Drugs or medications that have an over-the-counter equivalent or that can be lawfully obtained without a Physician's prescription, except insulin and insulin analogs.
- Any charge incurred for the administration of prescription drugs by a Physician.
- Drugs and substances that are Experimental or Investigational in nature.
- Drugs taken or given while an Insured Person is confined on an inpatient or outpatient basis in a Hospital, extended care facility, Skilled Nursing Home or similar institution that has a facility for providing drugs.
- Replacement of lost, stolen, destroyed or damaged prescriptions.
- Vitamins, prescription vitamins (except prenatal prescription vitamins), dietary supplements, cosmetic, health and beauty aids.
- Charges for drugs in excess of the Pharmacy Allowable Charges in the area where the drugs are dispensed.
- Therapeutic devices or appliances, support garments and other non-medical items regardless of their intended use, except as provided for treatment of diabetes.
- Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair or otherwise.
- Cosmetic drugs, except for acne medication, including Retin-A, Accutane, Avita and Differin, for an Insured Person under age 30 for treatment of acne vulgaris.
- Smoking cessation products.
- Blood and blood plasma.
- Appetite suppressants or any other drugs prescribed for weight loss.
- Injectable drugs for treatment of allergies.
- Infertility medications.
- Drugs or medications for treatment of sexual dysfunctions or disorders.
- Biological sera.
- Drugs or medications prescribed for an Injury or Illness arising out of employment.
- Drugs or medications furnished by any government organization or agency unless there is an unconditional legal obligation on the part of the Insured Person to pay such expenses, except Medicaid.
- Prescription Orders written by Physicians located outside the United States to be dispensed in the United States.
- Drugs or medications prescribed for treatment of Chemical Dependency.
- Drugs, including abortifacients, or devices intended to terminate a pregnancy.

VIII. Definitions:

Creditable Coverage means coverage provided under: a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); a group health benefit plan provided by a health insurance carrier or health maintenance organization, including a plan or policy providing coverage only for prescription drugs; an individual health insurance policy or evidence of coverage; Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1495c et seq.) (Medicare); Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.) (Medicaid) other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) (the program for pediatric vaccines); Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.) (Uniformed Services Former Spouses' Protection Act); a medical care program of the Indian Health Service or of a tribal organization; a state or political subdivision health benefits risk pool; a health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et seq.) (Federal Employees Health Benefits Act of 1959); a public health plan as defined in federal regulations; a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)); Title XXI of the Social Security Act (State Children's Health Insurance Program) and short-term limited duration coverage (coverage provided under a contract with an Insurance Company that has a specified contract expiration date that is within 12 months of the effective date of the contract, including any extensions that may be elected by the insured without the Insurance Company's consent).

Creditable Coverage does not include coverage under: accident-only insurance (including accidental death and dismemberment insurance); disability income insurance or a combination of accident-only and disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance (including mortgage insurance); coverage for onsite medical clinics; other coverage that is similar to the coverage under which benefits for medical care are secondary or incidental to other insurance benefits and as specified by federal regulations; if offered separately, coverage that provides limited scope dental or vision benefits; if offered separately, long term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits or any combination of those coverages or benefits; if offered separately, coverage that provides other limited benefits as specified by federal regulations; if offered as independent, non coordinated benefits, coverage for specified disease or illness; if offered as independent, non coordinated benefits, hospital indemnity or other fixed indemnity insurance; or Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C Section 1395ss) (Medicare and Medicaid Patient and Program Protection Act of 1987); coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.) (Uniformed Services Former Spouses' Protection Act), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate or contract of insurance.

Dependent means a person, under age 65, whose primary residence is with You and who is described below:
Your spouse;
Your unmarried child or step-child who is under age 25;
Your unmarried stepchild who is under age 25;
An unmarried child adopted by You, including a child You are seeking to adopt, who is under age 25;
Your unmarried grandchild who is dependent on You for Federal income tax purposes and under age 25 (coverage for a grandchild will not terminate solely because the Insured child is no longer Your dependent for Federal income tax purposes);
A child of any age who is disabled and dependent on You; and
A newborn child born to You for the first thirty-one (31) days after birth. After thirty-one (31) days, such child will remain a Dependent under this Policy only if notice of birth is received by Us before the next premium due date, following the 31 days after birth or within the Grace Period, and the required premium, if any, is paid.

Dependent also means an unmarried child, under age 25 for whom You have received a court or administrative order to provide medical support, including health insurance coverage.

Family Member means a parent, step-parent, grandparent, brother or sister of a child who is an eligible individual, provided the Family Member resides with the child.

Health Insurance means: individual or group health insurance, including any hospital and medical expense incurred policy, issued by an insurance company, a fraternal benefit society or a stipulated premium company; coverage of medical and health care services provided by an approved nonprofit health corporation; a health maintenance organization subscriber contract; coverage by a group hospital service plan, or a multiple employer welfare arrangement subject to Chapter 846 of the Texas Insurance Code; or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, including Medicaid (Title XIX of the Social Security Act).

Health Insurance does not include: accident only insurance (including accidental death and dismemberment); dental-only insurance; vision-only insurance; fixed indemnity insurance, including hospital indemnity insurance; credit insurance; long term care insurance; disability income insurance; coverage that provides other limited benefits as specified by federal regulations, if offered as independent,

non coordinated benefits; specified disease coverage; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical-payment insurance; coverage by Medicare (Parts A and/or B); Medicare Supplement or Medicare Select policies, regulated in accordance with federal law; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Insurance Company means: an insurance company; a health maintenance organization; an approved nonprofit health corporation; a fraternal benefit society; a stipulated premium insurance company; a group hospital service corporation; a multiple employer welfare arrangement; or any other entity providing a plan of Health Insurance or health benefits subject to state regulation.

IX. Renewability and Termination

A. Renewal

The Policy will be renewed each time the required premium payment is made on a timely basis.

B. Termination

Coverage will terminate for each person insured under this Policy:

1. 31 days after the day on which a premium payment for the Policy becomes due if payment is not made before that date; or
2. the earlier of the premium due date or the first day of the month that follows the date on which the Pool determines:
   a. the person is no longer eligible for coverage under the Pool; or
   b. the person is no longer a resident of the state of Texas, except for: a child who is a student under the age of 25 and financially dependent upon You; a child for whom You have received a court or administrative order to provide medical support, including health insurance coverage; or a child of any age who is disabled and dependent on You; or
   c. the person is 65 years old (does not apply to an Insured Person enrolled pursuant to Section IIa. if that person is not eligible for Medicare or to an Insured Person enrolled pursuant to Section IIb. if that person is not enrolled in Medicare Part B); or
3. 30 days after the date the Pool or its Administrator makes inquiry concerning the person's place of residence or any other eligibility criteria and the person does not reply; or
4. on the first day of the month that follows the primary insured's request for termination of coverage;
5. on the date of the person's death; or
6. on the date state law requires cancellation of this Policy.

X. Premiums

Premiums for the Pool may be paid monthly (by Automatic Bank Withdrawal), quarterly, semi-annually, or annually. Premium rates are based on Your age, gender, zip code, tobacco use and Medicare eligibility status. These rates are subject to change with at least 30 days notice. An initial premium payment for amount of the premium payment method selected must be submitted with an application for the Policy. A grace period of 31 days is allowed for the payment of premium, subject to the Renewability and Termination provisions above. We reserve the right to deduct the amount of any unpaid premium from any benefits paid to You or on Your behalf for charges incurred during the grace period.

XI. Complaints

If You have a complaint about the Pool, please contact the Administrator at its toll free number for the procedures for filing complaints. The Pool will not retaliate against any Insured Person because a complaint is filed by or on behalf of that person.

Policy Administered by:
Blue Cross and Blue Shield of Texas+
P. O. Box 6089
Abilene, TX 79608-6089
Toll Free Number: 1-888-398-3927 (Administrator)

SECTION A: APPLICANT INFORMATION (please print)

An incomplete application will be delayed and the effective date of your coverage may change if all required information is not received.

Last Name of Applicant	First Name of Applicant	Initial	Social Security Number

Age	Date of Birth (mm/dd/yy)	Sex (check one)	Marital Status (check one)	Do you use tobacco?*
		☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced; Date _______ ☐ Widowed; Date _______	☐ Yes ☐ No

Home Street Address	Apt. No.	Mailing Address (if different from Home Street Address)

City	State	Zip Code	City	State	Zip Code

County of Residence	Home/Cell Telephone	Work Telephone

Name of Custodial Parent (if applicant is a minor)	Social Security Number

SECTION B: FAMILY INFORMATION

List qualified dependents to be insured (see definition of dependents in Outline of Coverage).

Last Name	First Name	Initial	Relationship to Applicant	Social Security Number	Age	Date of Birth	Sex	Do they use tobacco?*
							M F	Yes No
							M F	Yes No
							M F	Yes No
							M F	Yes No
							M F	Yes No
							M F	Yes No

* Smoked cigarettes, cigars or a pipe or used chewing tobacco, nicotine chewing gum or snuff in the 12 months prior to this application.

+ A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of Blue Cross and Blue Shield Association

SECTION C: ELIGIBILITY

1. Eligibility Information (mark all situations that apply):

☐ I am a US Citizen or a permanent resident of the U.S. for at least 3 continuous years. Proof of citizenship or legal residency may be required.

☐ I am a resident of the State of Texas. **Send a copy of one of the following as proof of residency: front and back of your valid driver's license or current voter registration card or current utility bill indicating your physical address. If the application is for a child under age 18, please include proof of residency for the parents. Please provide current proof of residency for dependent spouse and dependents age 18 or older, if applying for coverage.**

☐ I had health insurance coverage for 18 months preceding this application with no gap of coverage greater than 63 days and the most recent coverage was through an employer sponsored plan, church plan or government plan or another state's high risk pool. **Send a copy of the Certificate of Creditable Coverage or documentation of the prior coverage. IF THIS BOX IS CHECKED, DO NOT COMPLETE SECTION 2 BELOW.**

2. Evidence of One of the Following Must Be Provided (mark one section and provide required documentation):

☐ I have received a notice of rejection or refusal to issue substantially similar individual health insurance for health reasons by an insurer. A rejection or refusal by an insurer offering only stop-loss, excess loss, or reinsurance coverage with respect to the applicant shall not be sufficient evidence. **Send a copy of the rejection letter from the insurance carrier.**

☐ My agent has certified that he/she is unable to obtain substantially similar individual health insurance for me with the insurance carrier he/she represents because I will be declined for coverage, as a result of my medical condition, based on the insurance carrier's underwriting guidelines. **Agent must complete Section I: AGENT INFORMATION.**

☐ I have been offered substantially similar individual health insurance coverage, but with a conditional rider excluding coverage for a medical condition. **Send a copy of the letter from the insurance carrier that includes the conditional rider exclusion. Note: COBRA and association group coverage are not considered individual coverage.**

☐ I have been diagnosed with one of the following medical or health conditions. **Send a signed and dated letter from your physician's office, stating the specific diagnosis and date of diagnosis. Please DO NOT send medical records. Check the condition(s) in the following list that applies to you:**

Cancer
- ☐ Malignant Tumor within 4 years (except skin cancer)
- ☐ Metastatic

Cardiovascular
- ☐ Artificial Heart Valve
- ☐ Cardiomyopathy
- ☐ Coronary Artery Disease
- ☐ Polyarteritis Nodosa
- ☐ Peripheral Vascular Disease, including Intermittent Claudication

Endocrine/Exocrine
- ☐ Diabetes Mellitus
- ☐ Cystic Fibrosis
- ☐ Addison's Disease

Gastrointestinal
- ☐ **Intestinal**
  - Crohn's Disease
  - Ulcerative Colitis
- ☐ **Liver**
  - Cirrhosis (non-alcoholic)
  - Wilson's Disease
  - Hepatitis

Hematopoietic
- ☐ **Anemia**
  - Sickle Cell
  - Splenic (True Banti's Syndrome)
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Thalassemia

Hodgkin's Disease
- ☐ Hodgkin's Disease

Immunological
- ☐ Acquired Immune Deficiency Syndrome (AIDS) or HIV Positive
- ☐ Lupus

Musculoskeletal
- ☐ Dermatomyositis or Polymyositis
- ☐ Muscular Atrophy or Dystrophy
- ☐ Myotonia
- ☐ Rheumatoid Arthritis
- ☐ Still's Disease
- ☐ Legge-Perthes Disease (Waldenstrom's Disease)

Neurological – Central Nervous System
- ☐ Cerebral Palsy
- ☐ Cerebral Vascular Accident (CVA)
- ☐ Epilepsy
- ☐ Huntington's Chorea
- ☐ Hydrocephalus
- ☐ Lead Poisoning with Cerebral Involvement
- ☐ Lobotomy
- ☐ Parkinson's Disease (if treatment within last 3 years)
- ☐ Guillian-Barre Syndrome

Neurological – Peripheral Nervous System (including Spinal Cord)
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Friedrich's Ataxia
- ☐ Myasthenia Gravis
- ☐ Paraplegia or Quadriplegia
- ☐ Sclerosis, Multiple, Disseminated or Postero-lateral
- ☐ Syringomyelia
- ☐ Tabes Dorsalis (Locomotor Ataxia)

Psychiatric
- ☐ Psychotic Disorders

Pulmonary
- ☐ Silicosis (Black Lung)

Renal
- ☐ Polycystic Kidney

Other
- ☐ Brain Tumor
- ☐ Down's Syndrome
- ☐ Scleroderma
- ☐ Transplants
  - Heart
  - Kidney
  - Liver
  - Lung

SECTION C: ELIGIBILITY - cont. (check all situations that apply)

Check all that apply with respect to you or any other person listed on this application (if one of these applies, you may not be eligible for coverage with the Texas Health Insurance Risk Pool):

Eligible for:

- ☐ Medicare (send a copy of your Medicare card)
- ☐ Medicaid (send a copy of your Medicaid card)
- ☐ Employer Group
- ☐ Association Group Policy
- ☐ COBRA or state continuation (Not eligible if in COBRA or state continuation period. COBRA/and or state continuation rights apply to each individual, not just employee)
- ☐ Conversion Policy
- ☐ Other Health Insurance

Check all that apply to you or any other person listed on the application:

- ☐ Currently confined to a county jail or a state prison
- ☐ Previously received benefits from the Texas Health Insurance Risk Pool (any benefits received will reduce benefits available under a subsequent policy; $1,500,000 lifetime maximum).
- ☐ Had prior coverage with Texas Health Insurance Risk Pool that was terminated for fraud.
- ☐ Terminated or lapsed coverage with the Texas Health Insurance Risk Pool within the last 12 months.

SECTION D: EMPLOYMENT INFORMATION (check all that apply)

- ☐ You are employed or have been employed at any time during the past 18 months.
- ☐ You have not been employed at any time during the past 18 months.
- ☐ Your spouse, if you are currently married or were divorced or widowed within the past 18 months, is employed or has been employed at any time during the past 18 months.
- ☐ Your spouse has not been employed at any time during the past 18 months.
- ☐ An employer form is required for any individual listed on page one who is age 18 or older.
- ☐ If the applicant is under age 25 and single, an employer form is required for each parent, step-parent and/or guardian.

Please complete and submit the Employment Information form for you or your spouse, as applicable. If married or divorced or widowed within the past 18 months, complete and submit the form for your spouse (even if the spouse is not applying for Texas Health Insurance Risk Pool coverage). If the applicant is a child, complete and submit the form for the dependent's parent(s), step-parents(s) and/or guardian(s):

SECTION E: OTHER INSURANCE

Supply the following information for the past 18 months for each person to be insured. **If a dependent had different coverage, provide information regarding coverage of each dependent. Attach a separate piece of paper if necessary. Please provide the Certificate of Creditable Coverage or other documentation for all health coverages in the past 12 months for credit against the preexisting condition limitation period. If you are currently on Medicare, please send a copy of your Medicare card.**

Name of policyholder		Date coverage terminated *
Name of previous health coverage carrier		Telephone number of previous carrier
Name of employer providing coverage (if any)		Telephone number of employer
Identification number of coverage		Group number (if any)
How long were you covered?	From / /	To / /
Is coverage still in force? ☐ YES ☐ NO	If **NO**, Why did coverage terminate?	

* If coverage is still in force - report "current" or scheduled termination date, if any.

SECTION F: HEALTH HISTORY

Have you or any person to be insured by the Texas Health Insurance Risk Pool received or had recommended medical advice, care or treatment, including taking prescription drugs, within the past six months? ☐ YES ☐ NO If **YES**, provide the following information. If more than one condition has been treated or family members are to be insured and additional space is needed, attach a separate piece of paper providing the requested information for each condition of each person to be insured.

Name of Person Treated	Date of Advice/Care/Treatment
Advice, Care or Treatment Received	
Condition Treated	Treating Physician
Name of Person Treated	Date of Advice/Care/Treatment
Advice, Care or Treatment Received	
Condition Treated	Treating Physician
Name of Person Treated	Date of Advice/Care/Treatment
Advice, Care or Treatment Received	
Condition Treated	Treating Physician

SECTION G: APPLICANT'S DISCLOSURE AUTHORIZATION AND DECLARATION

I declare that no person named in this application is currently insured by a Texas Health Insurance Risk Pool policy. The foregoing statements and answers are full, complete, and true to the best of my knowledge and belief; and any coverage issued will be in full reliance upon this representation. I understand and agree that no coverage shall be effective until all requirements have been completed. I understand and agree to pay an application fee equal to the premium mode I have selected. This payment is only a deposit that will be returned if my application is denied or applied to any premium charges if my application is accepted. I understand and agree that the deposit of my application fee does not constitute acceptance of my application by the Texas Health Insurance Risk Pool.

I understand and agree that referring agents are not authorized to interpret, amend, or alter the terms of the Texas Health Insurance Risk Pool policy, nor are referring agents authorized to bind Texas Health Insurance Risk Pool in any way. I understand and agree that premiums charged for coverage and the coverage provided by the Texas Health Insurance Risk Pool are subject to change by the Board of Directors. **I understand that my coverage will become effective on the first of the month following approval and acceptance of the application by Texas Health Insurance Risk Pool.**

I understand that preexisting conditions of an insured person will not be covered by the Texas Health Insurance Risk Pool policy until the policy has been in force for twelve months unless the insured person is approved for a waiver of the preexisting condition limitation period because of previous creditable coverage. A preexisting condition is a disease or medical condition: for which the existence of symptoms would cause an ordinarily prudent person to seek diagnosis, care or treatment during the six months before an insured person's effective date of coverage; or for which medical advice, care or treatment was recommended or received during the six months before an insured person's effective date of coverage. Preexisting condition includes a preexisting pregnancy or a complication of a preexisting pregnancy, whether the complication occurs before or after the effective date of coverage. Preexisting condition does not include genetic information, in the absence of a diagnosis of the condition related to the genetic information.

I permit any physician, pharmacist, hospital or other health care provider, insurer, prepayment organization or other health plan provider to give the Texas Health Insurance Risk Pool, the Administrator or its designated representative any medical information about me or my dependents, including information about physical and mental health, medical history and drug or alcohol use. This information will be used to evaluate your eligibility for the Texas Health Insurance Risk Pool policy and claims for benefits. A reproduction of this authorization shall be as valid as the original.

The information you provide on this form and any attachments is private data under Texas law. The law does not require you to provide any data, but failure to do so will result in loss of eligibility for the Texas Health Insurance Risk Pool. By providing this data, you authorize the Texas Health Insurance Risk Pool and its Administrator to use and disclose the data as follows: any data you provide may be made available to the employees, agents, directors, officers of the Texas Health Insurance Risk Pool, the Administrator or legal counsel. It may also be made available to provider peer review panels or consultants, the actuarial or research organizations, or other persons authorized by law to receive such data.

I have read the above statement, and I agree to supply the data on this form with full knowledge of the information provided in that statement. If I am applying based on an agent's certification of my ineligibility for substantially similar coverage from an insurer or health maintenance organization, based on my medical condition(s), I hereby certify that the medical information provided on this application by the agent is correct and I agree that a copy of the agent's statement, SECTION I, may be furnished to the named insurer or HMO.

Signature of Applicant	Date (mm/dd/yy)	Signature of Custodial Parent (if applicant is under age 18)	Date (mm/dd/yy)
X		**X**	

SECTION H: PREMIUM PAYMENT METHOD

Choose One: (Future change to a lower deductible is not allowed. Only one increase in the deductible will be allowed during a calendar year.)

- ☐ **PLAN I REGULAR** ($1,000 Deductible)
- ☐ **PLAN I MEDICARE** ($1,000 Deductible)
- ☐ **PLAN II REGULAR** ($2,500 Deductible)
- ☐ **PLAN II MEDICARE** ($2,500 Deductible)
- ☐ **PLAN III REGULAR** ($5,000 Deductible)
- ☐ **PLAN III MEDICARE** ($5,000 Deductible)

Please Bill Me:

- ☐ Annually (Direct billed once a year)
- ☐ Semi-Annually (Direct billed twice a year)
- ☐ Quarterly (Direct billed every three months)
- ☐ Monthly Automatic Bank Deduction (Please attach a copy of a voided check, not a deposit slip, with the correct account number and fill out the authorization agreement on the next page.)

Using the table below, calculate the amount of premium due with this application. Payment should be by personal check, money order or cashier's check. **Company checks are accepted only if applicant is the owner or co-owner of a business and such business does not provide an employer health plan.**

Premium Calculation Table

	Applicant's/Dependent's First Name	Age	Sex	Tobacco user?*	First 3 Digits of Zip Code	Applicable premium amount from rate table**
1						
2						
3						
4						
5						
6	**Subtotal**					
7	**Initial premium is determined by the premium payment method selected:** Monthly = 1 month Quarterly =3 months Semi-Annually = 6 months Annually = 12 months					
8	Multiply line 6 by the number of months determined on line 7 and **INCLUDE THIS AMOUNT WITH THE APPLICATION**. **TOTAL**					

*Smoked cigarettes, cigars or a pipe or used chewing tobacco, nicotine chewing gum or snuff in the 12 months prior to this application.

**Premium amount is calculated based on age on the policy effective date.

SECTION H (cont.): BANK DRAFT FORM

Complete this section only if you are requesting to pay premiums monthly.

Authorization Agreement for Monthly Automatic Bank Deduction of Insurance Premium

Complete and sign the Authorization Agreement for monthly Automatic Bank Deduction of Insurance Premium if you have chosen monthly payments. Please note:

- **Attach** a sample of your check marked "VOID".
- Verify your account number with your banking institution. (Frequently, the account number listed on a check includes or removes digits from the actual account number.)

As a convenience to me (or us if this is a joint account), I (we) hereby request and authorize you to pay and charge to my (our) account checks or electronic debits drawn on my (our) account by you and payable to the order of the Texas Health Insurance Risk Pool. I (we) agree that your rights in respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me (us). This authority is to remain in effect until revoked by me (us) in writing and until you actually receive such notice. I (we) agree that you shall be fully protected in honoring any such check or electronic debit.

I (we) further agree that if any such check or electronic debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Name of Account Holder(s) 1.			2.
Bank Name			Checking Account Number: (Do not use a savings account.)
Bank Address			
City	State	Zip Code	Routing Number:

Signature of Account Holder(s)

Name (please print)		Name (please print)	
Signature X	Date (mm/dd/yy)	Signature X	Date (mm/dd/yy)

To The Financial Institution named: In consideration of your participating in a plan which the Texas Health Insurance Risk Pool ("Company") has put into effect by which amounts due on policies of insurance are collected by checks drawn or pre-authorized electronic debits originated by the Company on the accounts of persons who are responsible for these payments, the Company does hereby agree that:

(1) It will indemnify and hold you harmless from any liability to any person arising out of the payment by you of any check or electronic debit, whether or not genuine, originated by the Company in the regular course of business for the purpose of payment, or arising out of the dishonor by you whether with or without cause, or intentionally or inadvertently, of any such check or electronic debit, whether or not such claim or liability asserted against you be based upon the forfeiture or alleged forfeiture of a policy of insurance the premium on which is sought to be collected by the Company by any such check or electronic debit; and

(2) Without limitation on the foregoing indemnities, it will refund to you any amount erroneously paid by you on any such check or electronic debit if claim for the amount of such erroneous payment is made by you within six months from the date of the check or electronic debit on which such erroneous payment was made; and

(3) Your participation in the plan or that of the depositor may be terminated by written notice from either party to the other, likewise, your participation and that of the Texas Health Insurance Risk Pool may be terminated by 30 days written notice from either party to the other.

Texas Health Insurance Risk Pool

D. Gregory Barbutti
Secretary/Treasurer
Authorized in a resolution adopted by the Board of Directors

SECTION I: AGENT INFORMATION (if applicable)

To be completed if an Insurance Agent assisted with this application.
(Information is required to process the $50 agent referral fee)

Applicant Name			Applicant Social Security #
Agent Name (Printed)			Texas Insurance License No. (Required)
Business or Agency Name			Social Security or Tax ID #
Business or Agency Address			Work Telephone Number
City	State	Zip Code	Fax Telephone Number

I understand that Texas Insurance Code statutes, §1501.352 and §1506.159 prohibit an agent from attempting to arrange or assist in excluding an eligible individual from an employer health benefit plan, specifically by attempting to arrange or assist in obtaining coverage from the Texas Health Insurance Risk Pool. I hereby certify that, if the applicant is employed, his employer does not have employer health coverage in effect nor does the employer intend to obtain such coverage within the six months after the date of this application.

Agent's Signature	Date
X	

If Agent is certifying applicant's eligibility under Section C: ELIGIBILITY, Agent must also complete the following

Medical Condition and Approximate Date(s) of Diagnosis	Name and Address of Attending Physician
Name and address of Insurer or Health maintenance Organization that will NOT accept Applicant.	

I hereby certify that I believe I am unable to obtain individual health insurance substantially similar to that offered by the Texas Health Insurance Risk Pool for this applicant from the indicated insurer or HMO, with which I am appointed, because the current underwriting guidelines of such insurer or HMO reflect a declination for the applicant's medical condition(s).

Agent's Signature	Date

The Pool reserves the right to require an attending physician's statement. A copy of this certification may be provided by the Texas Health Insurance Risk Pool to the named insurer or HMO.

CHECKLIST FOR APPLICATION

Must Be Completed and Returned with Application

BEFORE MAILING YOUR APPLICATION, PLEASE COMPLETE THIS CHECKLIST, WHICH MUST BE SUBMITTED WITH YOUR APPLICATION.

1. Application SECTION C: ELIGIBILITY INFORMATION

a. I have included proof of Texas residency, including physical address, by providing **one** of the items below for each person, age 18 or over, to be covered:

___ A copy of the front and back of a valid Driver's License.
or ___ A copy of a valid Voter Registration Card.
or ___ A copy of a current Utility Bill

If application is for a child under age 18, please include proof of Texas residency for parent(s).

b. I have selected and included proof of **one** of the following:

___ I have maintained health insurance coverage for the past 18 months or more, with no gap in coverage greater than 63 days and the last coverage through an employer sponsored plan, church or government plan, or another state's high risk pool. I have enclosed a termination letter* and a copy of my previous ID card, showing when coverage began, or a Certificate of Creditable Coverage from my previous insurance carrier or, if a self-funded plan, from my employer.
or ___ I have enclosed a letter of notice of rejection* from one insurer for substantially similar individual health insurance coverage due to medical reasons.
or ___ My agent has completed the agent certification, Section I on the application indicating that I am unable to obtain substantially similar individual health insurance, as a result of a medical condition, based on the insurance carrier's underwriting guidelines. The insurance company name and address are included.
or ___ I have enclosed a copy of a letter* offering substantially similar individual health coverage by an insurer with a conditional rider excluding coverage for medical reasons (COBRA and association group coverage are not individual coverage).
or ___ I have enclosed a letter from my physician's office, indicating that I have been diagnosed with one of the Pool's qualifying medical conditions, listed on the application, including the date of diagnosis.

2. Application SECTION D: APPLICANT/SPOUSE EMPLOYMENT

___ I have included the completed Employment Information form(s).

3. Application SECTION E: OTHER INSURANCE (for Preexisting Condition Waiting Period Credit)

___ I have enclosed a termination letter* and a copy of my previous ID card, showing when coverage began, or a Certificate of Creditable Coverage from my previous insurance carrier or, if a self-funded plan, from my employer. NOTE: This documentation is not required to complete the application process; however, it is required for preexisting condition waiting period credit.

4. Application SECTION H: PREMIUM PAYMENT METHOD

a. ____ I have selected a Deductible Plan.

b. ____ I have INCLUDED a personal check, money order or cashier's check for the initial premium payment (see Section H of the application for the required premium amount; checks must be payable to the Texas Health Insurance Risk Pool). Note: company checks are accepted <u>only</u> if applicant is the owner or co-owner of business and business does not provide an employer health plan.

c. For **all applicants paying monthly:**

____ I have completed page 7 of the application.
____ I have included a voided check.

***Note:** The document must be written on insurance company letterhead with the applicant's name included.

TEXAS HEALTH INSURANCE RISK POOL
EMPLOYER EMPLOYMENT VERIFICATION

Copies of this form are to be completed by you and your current employer and your spouse's current employer (even if your spouse is not covered or to be covered by the Pool). If you are the person named below, and under the age of 25 and single, the current employer of each of your parents must complete this form. If you are self-employed, your employer is your company. If you are unemployed or retired, SECTION B does not need to be completed.

Individual's Information (SECTION A)	
Your Name:	Your Social Security Number or Unique ID Your Spouse's Name (if any):

Are you employed? ☐Yes ☐No Is your spouse employed? ☐Yes ☐No

If yes to either question, the applicable employer(s) must complete Section B below.

Are you self-employed? ☐Yes ☐No Is your spouse self-employed? ☐Yes ☐No

If yes to either question, complete Section B for the applicable business(es).
If no employer or not self-employed, please complete Section A only and return.

Marital Status---☐Single ☐Married ☐Divorced ☐Widowed

If you checked married, and your spouse is employed, please complete a separate form for your spouse's employment information. If you have been divorced or widowed within the last 18 months, please provide the last employment information for your former spouse.

Employment Information for ☐You ☐Spouse ☐Mother ☐Father

If you or your spouse is unemployed or retired, please provide the date of last employment or retirement:

You______________________________ Spouse_______________________________

If you have been unemployed or retired more than 18 months please fill in your last employer's name only. If you have been unemployed or retired less than 18 months please also provide your last employer's phone number.

Last Employer Name:____Phone:___________________________

Your Signature	Date

Employer Information (To be completed and signed by current Employer only) (SECTION B)	
Employer/Business Name:	Telephone Number:
Address:	Number of Employees (including yourself & including owner if employed):
Employee's Name:	
Date of Employee Hire or Business Start Date:	Waiting Period for Employer Health Coverage (if any):
Does employer provide group health benefit coverage, either insured or self-insured?	☐Yes ☐No
If the employer does not provide a group plan, is coverage for the employees provided through individual health insurance coverage?	☐Yes ☐No
If insured, either through a group policy or individual policies, the name and telephone number of insurance company:	

(SECTION B continued)	
Is coverage available for dependents of the employee?	☐Yes ☐No
Is the person, named above as the employee, eligible for employer's coverage? If no, please explain:	☐Yes ☐No
Does the employer pay all or part of the cost of employee coverage for any employees? If no, please explain:	☐Yes ☐No
If the employer pays all or part of the cost for employee coverage, is the amount paid for insurance included in the employees' taxable wages? If no, please explain:	☐Yes ☐No
If yes, can the employee use the amount paid for other purposes besides health insurance premiums? If yes, please indicate the other permissible uses:	☐Yes ☐No
If the employer does not currently provide coverage, was coverage provided during the last 12 months?	☐Yes ☐No
Date of and reason for coverage cancellation/termination: If insured, the name and telephone number of insurance company:	
Does the employer intend to provide health coverage for employees in the next 6 months?	☐Yes ☐No
Is the employer working with an agent or third party administrator to secure or establish group coverage? If yes, the name and telephone number of the agent or the TPA:	☐Yes ☐No
Does the employer pay for or reimburse or intend to pay or reimburse the person, named above as the employee, for all or part of the Pool premium, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan)?	☐Yes ☐No

I understand that Texas Insurance Code statutes, §1501.352 and §1506.159 prohibit an agent, a third party administrator or insurer from attempting to arrange or assist in excluding an eligible individual from an employer health benefit plan, specifically by attempting to arrange or assist in obtaining coverage from the Texas Health Insurance Risk Pool. I hereby certify that the above answers are true and correct. I further understand that a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as the Texas Health Insurance Risk Pool, for a person who is ineligible for such plan, is a violation of the anti-fraud provisions of the Health Insurance Portability and Accountability Act, 18 USC §1035, to which civil and criminal penalties, including imprisonment, can apply.

Employer's Signature: _________________________ Title: _______________________________

Date: ____________ Printed Name: _______________________

TEXAS HEALTH INSURANCE RISK POOL
EMPLOYER EMPLOYMENT VERIFICATION

Copies of this form are to be completed by you and your current employer and your spouse's current employer (even if your spouse is not covered or to be covered by the Pool). If you are the person named below, and under the age of 25 and single, the current employer of each of your parents must complete this form. If you are self-employed, your employer is your company. If you are unemployed or retired, SECTION B does not need to be completed.

Individual's Information (SECTION A)	
Your Name:	Your Social Security Number or Unique ID Your Spouse's Name (if any):

Are you employed? ☐Yes ☐No Is your spouse employed? ☐Yes ☐No

If yes to either question, the applicable employer(s) must complete Section B below.

Are you self-employed? ☐Yes ☐No Is your spouse self-employed? ☐Yes ☐No

If yes to either question, complete Section B for the applicable business(es).
If no employer or not self-employed, please complete Section A only and return.

Marital Status---☐Single ☐Married ☐Divorced ☐Widowed

If you checked married, and your spouse is employed, please complete a separate form for your spouse's employment information. If you have been divorced or widowed within the last 18 months, please provide the last employment information for your former spouse.

Employment Information for ☐You ☐Spouse ☐Mother ☐Father

If you or your spouse is unemployed or retired, please provide the date of last employment or retirement:

You______________________________ Spouse_______________________________

If you have been unemployed or retired more than 18 months please fill in your last employer's name only. If you have been unemployed or retired less than 18 months please also provide your last employer's phone number.

Last Employer Name:____Phone:__________________________

Your Signature	Date

Employer Information (To be completed and signed by current Employer only) (SECTION B)	
Employer/Business Name:	Telephone Number:
Address:	Number of Employees (including yourself & including owner if employed):
Employee's Name:	
Date of Employee Hire or Business Start Date:	Waiting Period for Employer Health Coverage (if any):
Does employer provide group health benefit coverage, either insured or self-insured?	☐Yes ☐No
If the employer does not provide a group plan, is coverage for the employees provided through individual health insurance coverage?	☐Yes ☐No
If insured, either through a group policy or individual policies, the name and telephone number of insurance company:	

(SECTION B continued)

Is coverage available for dependents of the employee? ☐Yes ☐No

Is the person, named above as the employee, eligible for employer's coverage? ☐Yes ☐No
If no, please explain:

Does the employer pay all or part of the cost of employee coverage for any employees? ☐Yes ☐No
If no, please explain:

If the employer pays all or part of the cost for employee coverage, is the amount paid for insurance included in the employees' taxable wages? ☐Yes ☐No
If no, please explain:

If yes, can the employee use the amount paid for other purposes besides health insurance premiums? ☐Yes ☐No

If yes, please indicate the other permissible uses:

If the employer does not currently provide coverage, was coverage provided during the last 12 months? ☐Yes ☐No

Date of and reason for coverage cancellation/termination:

If insured, the name and telephone number of insurance company:

Does the employer intend to provide health coverage for employees in the next 6 months? ☐Yes ☐No

Is the employer working with an agent or third party administrator to secure or establish group coverage? ☐Yes ☐No
If yes, the name and telephone number of the agent or the TPA:

Does the employer pay for or reimburse or intend to pay or reimburse the person, named above as the employee, for all or part of the Pool premium, either directly or indirectly, including through a Health Reimbursement Arrangement (HRA) or Section 125 Plan (Cafeteria Plan)?

☐Yes ☐No

I understand that Texas Insurance Code statutes, §1501.352 and §1506.159 prohibit an agent, a third party administrator or insurer from attempting to arrange or assist in excluding an eligible individual from an employer health benefit plan, specifically by attempting to arrange or assist in obtaining coverage from the Texas Health Insurance Risk Pool. I hereby certify that the above answers are true and correct. I further understand that a false or fraudulent statement or representation, made in order to procure coverage under a health benefit plan, including a public plan such as the Texas Health Insurance Risk Pool, for a person who is ineligible for such plan, is a violation of the anti-fraud provisions of the Health Insurance Portability and Accountability Act, 18 USC §1035, to which civil and criminal penalties, including imprisonment, can apply.

Employer's Signature: __________________________ Title: ________________________________

Date: _____________ Printed Name: ________________________