



GETTINGUSCOVERED

Welcome to GettingUSCovered! (Please complete ALL documentation thoroughly)

Please type or print in black or blue ink. All sections must be filled out completely. A voided check and required documents must be submitted with the signed and dated application. For questions while completing this form, please contact us on our toll-free number: (877) 779-0387.

The deadline to submit your application is the 15th of every month to be considered for an effective date the first of the following month. If the 15th falls on a weekend or Federal holiday, then the application is due in our office the Friday prior to the 15th.

IMPORTANT—Please Read!

Eligibility:

To be eligible for the GettingUSCovered plan, you must be a Colorado resident and a U.S. Citizen (or have a lawful presence in the U.S), have been uninsured for the past six months and have a pre-existing condition.

Instructions:

To receive an approval you must:

- ◆ Provide ALL requested information:
 - ◆ Proof of pre-existing condition
 - ◆ Proof of Colorado residency
 - ◆ Proof of U.S. Citizenship or lawful presence in the United States
- ◆ Sign and date in all places indicated.
- ◆ Submit application by the deadline of the 15th of the month. You will be notified in writing when your application is approved.
- ◆ Submit a voided personal check with the application. A separate voided check is required for each applicant, as premiums are automatically drafted via EFT each month.

Applications must be printed out, signed and dated. Online applications cannot be processed without supporting documents.

Please submit all required documents with the application, including a voided check, and mail, scan, fax or deliver to:

**GettingUSCovered
425 South Cherry St.
Suite 150
Glendale, Co 80246**

You may email your application and documents to: emailus@gettinguscovered.org or fax to: (720) 542-6765.

We do not provide copies, so please make copies prior to submitting your application.

GettingUSCovered provides insurance to uninsured individuals with pre-existing medical conditions. Eligible individuals who submit completed applications and all required documentation will not be denied insurance.

**Missing documentation
could delay your effective date.**

GETTINGUSCOVERED APPLICATION REQUIREMENTS CHECK LIST

To receive an approval, you must include **all** of the required documentation. Documentation must be in the applicant's name. It is your responsibility to submit a complete application, including required documents to 425 S. Cherry St. #150, Glendale, CO 80246. Applications may also be faxed or emailed. Incomplete applications without all the proper documentation will be returned or pended.

A complete application consists of the following items:

1. Application for coverage

You must complete the entire application. Do not leave any areas blank. If you are missing information on your application, GettingUSCovered cannot and will not alter, add, or fill-in information for you. We will not transfer information from supporting documentation to your application. Your original signature is required unless you are applying for a minor, then the parent or guardian's signature is required.

2. Premium payment:

Your monthly payment will be drafted each month from your bank account. A separate voided check is required for each applicant to provide verification of account information. Only personal checks are acceptable; business checks or DBA checks will not be accepted. Neither employers nor third parties can pay for or reimburse the member for any portion of the premium. Please note that upon approval, your bank account will be drafted for the initial premium and on the last business day of each month thereafter. Any changes to your account information or status must be submitted via a change form, available on our website:
www.gettinguscovered.org.

3. Proof of Colorado residency

All applicants must be a Colorado resident. If the applicant is a minor, please send a copy of residency in the Parent or Guardian's name. One of the following documents should be submitted:

- Colorado Driver's License or Identification Card; (clear legible copy – issue date must be legible)
- Most current Colorado State Income Tax Return or Federal Tax Return, reflecting a Colorado address
- Utility bill in applicant's name (or parent's name, if applicant is a minor)

4. Proof of U.S. Citizenship or lawful presence in the U.S.

All applicants must be a U.S. Citizen or lawful resident of the U.S. A copy of one of the following documents must be submitted with a photo id.:

- U.S. Passport (additional photo id is not required)
- Social security card
- Certificate of naturalization (Form N-550 or N-570)
- Other documentation you have filed with the I.C.E. to provide proof of legal U.S. residency
- State birth certificate
- Certificate of U.S. Citizenship (Form N-560 or N-561)

5. Proof of Pre-Existing Condition

You must document eligibility. Submit one or more of the following:

- Insurance company denial letter addressed to applicant (vs. agent) and dated within 60 days of this application
- Acceptance letter for individual insurance of a new policy with an exclusion or reduction of coverage dated within 60 days of this application
- Physician statement documenting the medical condition that is stated exactly as listed on GettingUSCovered's list, as listed in Section 2

We do not provide copies, so please make copies prior to submitting your application.

Section 1: Applicant Information

Requested effective date: _____

Social Security Number ____-____-____ Date of Birth ____/____/____ (mo/day/year) Age ____

Last Name: _____ First Name: _____ Middle Initial ____ Gender: ____

Mailing Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: () _____ Cell phone: () _____

Email: _____

PLEASE COMPLETE IF APPLICANT IS UNDER THE AGE OF 18:

Father's Name: _____ Mother's Name _____ Legal Guardian Name _____

Social Security #: _____ Social Security #: _____ Social Security #: _____

Is your principal or primary home in Colorado? ____ Yes ____ No

Have you ever been enrolled in CoverColorado? ____ Yes ____ No If Yes, when? _____

Have you ever been enrolled in a State High Risk Pool other than CoverColorado? ____ Yes ____ No

If Yes, what dates did you have coverage? _____ What state? _____

Have you ever been enrolled in any Federal Qualified High Risk Pool ? ____ Yes ____ No

If Yes, what dates did you have coverage? _____ What state? _____

Have you Smoked Cigarettes, Cigars, Pipes or used chewing tobacco, snuff, or nicotine chewing gum in the last 12 months? ____ Yes ____ No

Are you a United States citizen? ____ Yes ____ No

If no, do you have a lawful presence in the United States? ____ Yes ____ No.

All applicants must provide proof of U.S. Citizenship or lawful U.S. presence.

Please refer to the Application Checklist for a list of eligible documentation.

Section 2: Determination of Eligibility

I CERTIFY that I am eligible for coverage because I am a resident of the State of Colorado and a US citizen or have a lawful presence in the United States.

I CERTIFY that I have not had health insurance for a minimum of six months prior to submitting this application.

I CERTIFY that I qualify for one or more of the following reasons:

Please check the proof of medical eligibility that you will be submitting with your application.

#-1 REJECTION FOR COVERAGE DUE TO MEDICAL CONDITION

I received and attached a denial letter addressed directly to me from an insurance company. It confirms that I have applied for coverage and have been rejected due to a medical condition. A copy of the denial letter from the health insurance company is submitted with my application. The date of the denial letter cannot be more than 60 days prior to the date of this application.

#-2 ACCEPTANCE WITH PRE-EXISTING REDUCTION OR EXCLUSION

I have made a new application for other health insurance and was accepted with a reduction or exclusion of coverage for a pre-existing medical condition. A copy of the notice from the health insurance company must accompany your application. Exclusion letter cannot be more than 60 days before the date of this application.

#-3 DIAGNOSED WITH MEDICAL CONDITION LISTED BELOW

I have been diagnosed with one or more of the medical conditions listed below. **Please circle all that apply.** A letter from your physician with the physician's name, address, specialty or a signed prescription form with your name and exact diagnosis must accompany your application.

AIDS/HIV+	Crohn's Disease	Leukemia	Paraplegia or Quadriplegia
Alcohol/Drug Abuse	Cystic Fibrosis	Lou Gehrig's Disease	Parkinson's Disease
Alzheimer's Disease	Diabetes	Lupus Erythematosus Disseminate	Primary Polycythemia
Anorexia	Emphysema	Major Depressive Disorder	Schizo Affective Disorder
Bipolar Disorder	Hemophilia	Malignant Tumor, last 4 years	Schizophrenia
Cancer	Hepatitis	Multiple or Disseminated Sclerosis	Obsessive Compulsive Disorder
Cerebral Palsy	Hodgkin's Disease	Muscular Dystrophy	Stroke
Cirrhosis of the Liver	Huntington's Disease	Myasthenia Gravis	
Cleft Palate	Kidney Disease	Panic Disorder	

Section 3: Employment and Coverage Information

If you are covered under any health insurance plan, you do not qualify for the GettingUSCovered.

You must complete the following. (If applicant is a minor, the parent or legal guardian must complete):

Are you employed? Yes No Full-time Part-time Self Retired Unemployed

Name of employer: _____ Phone: () _____

Address of employer: _____ How long employed? _____

City: _____ State: _____ Zip: _____

Does your employer offer health insurance coverage? Yes No

If yes, are you covered under your employer's plan? Yes No If no, what is the reason you are not covered? _____

Is your premium paid or reimbursed, either in whole or in part by your employer? Yes No

Are you married? Yes No If married, is your spouse employed? Yes No

Full-time Part-time Retired Self Unemployed

If married, are you covered under your spouse's plan? Yes No If no, what is the reason you are not covered? _____

Have you been covered under an individual, group or employer plan within the last six months? Yes No

Complete the following for the last health insurance coverage you had:

Name of policy holder: _____

Insurance company or High Risk Pool name: _____

Member ID: _____ Phone number: _____

Original effective date of policy: _____ Termination date of policy: _____

Reason for termination of policy: _____

Are you covered for medical assistance through the Medicaid program? Yes No

Are you covered under Medicare? Yes No

Do you receive Social Security Disability Income? Yes No If yes, date effective: _____

Please provide a Certificate of Credible Coverage from the last health insurance coverage you had.

Section 4: Agent Information

Did you have assistance completing this application from an agent? If yes, the agent should complete the section below and submit with this application. A \$25 referral fee will be paid to the assisting agent in completing this application as long as the application is complete with ALL supporting documentation and the application is approved.

NOTE: There is no contractual relationship established by the agent in completing this application, and the agent does not represent the GettingUSCovered or its administrator and has no responsibility for any action taken by either party.

Applicant name: _____

Agent/Producer name: _____

Colorado insurance producer's license number: _____

Social Security # : _____

Business or agency name: _____

Tax ID Number: _____

Business or Agency license number: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____

Email: _____

I have advised my client that they are not eligible for GettingUSCovered if their employer or a third party institution subsidizes or reimburses any portion of their premium.

Agent's Signature: _____

Make check payable to: _____

Date: _____

Signature is required by the assisting agent on all applications.

Section 5: Banking Information

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

NOTE: If any financial information changes, you must notify GettingUSCovered promptly to allow for system and banking changes to occur. A change form, located at www.gettinguscovered.org (Resources and Links/Member Forms), must be submitted. We will not be held accountable for any bank charges or fees.

Please provide the following information about the premium payer if the premium payer is not the applicant*:

First Name: _____ Last Name: _____ Relationship to applicant: _____

Street Address: _____ Apt#/Unit# _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Email: _____

I hereby request and authorize the financial institution named below, to pay or charge to my account, checks / drafts drawn on my account by and payable to the order of GettingUSCovered, provided there are sufficient collectable funds in my account to pay such checks / drafts upon presentation. I agree that your rights in respect to each such check / draft shall be the same as if it were a check / draft drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check / draft.

I further agree that if any such check / draft is not honored, whether with or without cause and whether intentionally or inadvertently, you shall have no liability whatsoever even though such action results in forfeiture of medical insurance coverage. This authorization is to remain in effect until you receive 15 days written notice from me to revoke it.

Completely fill in the following section and sign below.

Name of Applicant: _____

Name of Financial Institution: _____

Checking _____ Savings _____ Routing # _____ Account # _____

Financial Institution Address: _____

City: _____ State: _____ Zip: _____

Name of Account Holder: (please print) _____

Signature of Account Holder: _____ **Date:** _____

To FINANCIAL INSTITUTION: *In consideration of your honoring pre-authorized drafts drawn against depositors of your financial institution for the payment of amounts to GettingUSCovered, we agree that no liability or responsibility shall attach to your financial institution as a result of honoring or not honoring such checks / drafts, and we further agree to hold you harmless from and reimburse you for any loss resulting as a consequence of your actions taken pursuant to your agreement to honor such checks / drafts. We shall defend any action brought against you by any of your depositors or any other person because of your compliance with the pre-authorized check / draft plan.*

* Premium payer must be a family member; employers and third party institutions cannot pay the premiums.

Section 6: Certification

- I certify that the foregoing statements are true and accurate to the best of my knowledge and belief. I understand that no coverage will be effective until all documentation is provided. When approved and payment has processed, coverage will become effective the first day of the month following approval.
- I certify that I am a U.S. citizen or am lawfully present in the United States. I agree to notify GettingUSCovered of any change in my status. I understand I may be required to provide ongoing proof of my status and that failure to do so may result in the termination of this policy.
- I understand that if I obtain any other health coverage or am no longer a Colorado resident, I must notify GettingUSCovered and this coverage will be terminated.
- I understand that I am eligible for GettingUSCovered only if I have had no health insurance coverage within the six months immediately prior to the date of my application submission.
- I understand that any agent assisting me with this application is not authorized to determine eligibility, make or modify contracts, or waive any of the GettingUSCovered's rights or requirements. I understand that once I am an enrollee, no other person, including my agent, may obtain or discuss my Protected Health Information unless I have signed a Personal Representative form from GettingUSCovered.
- I understand that any health care provider who has provided or proposes to provide health care services to me is allowed to release my Protected Health Information to GettingUSCovered or its designated representative, for claims payment, treatment, utilization review, disease or case management services or quality improvement purposes. I agree to assign payment for services provided to the health care professionals or health care facilities that provided the services, unless otherwise agreed to by GettingUSCovered. I acknowledge that I will be personally financially responsible for payment of my premium unless I have made other arrangements for payment through a trust fund, parent or family member.

I understand that if I knowingly give false, incomplete or misleading information, coverage may be denied or revoked and I may be subject to fines, penalties or criminal charges.

Print Applicant's Full Name: _____

Signature of Applicant (or parent/guardian/legal representative if applicant is under age 18 or declared legally incompetent) :

_____ Date: _____

If you are signing and are not the applicant, please print your name and check one of the following:

Name of person signing application: _____
_____ Mother _____ Father _____ Legal Guardian _____ Legal Representative

If you are the Legal Representative please provide a copy of the document establishing your legal authority.

Please note:

- **Deadline to submit your application is the 15th of the month** to qualify for the 1st of the following month effective date. Applications received after the 15th of the month will not be processed until the following month. If the deadline falls on a weekend or Federal holiday, your application must be in to our office the Friday before.
- ◆ You will be notified in writing when you are approved, denied or a request for additional information is required.

Website: www.gettinguscovered.org

Email: emailus@gettinguscovered.org

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2010 Rates

Age	Non-smoker	Smoker
0-18	\$120	\$143
19-24	\$157	\$190
25-29	\$179	\$222
30-34	\$197	\$252
35-39	\$229	\$295
40-44	\$270	\$351
45-49	\$329	\$427
50-54	\$390	\$513
55-59	\$472	\$633
60-64	\$551	\$740

To calculate the rates, multiply the rate above by the Geographic Rate Factor for the county you live in.

Select the smoker rate if you have used any tobacco product within the last 12 months.

Geographic Rate Factor		Counties
Area 1	0.96	All others
Area 2	1.02	Adams, Arapahoe, Broomfield, Clear Creek, Denver, Dolores, Fremont, Gilpin, Jefferson, Larimer, Park, Teller, Weld
Area 3	1.06	Elbert, Garfield, Gunnison, Jackson, Lake, Logan, Moffatt, Morgan, Phillips, Routt, Sedgwick, Summit, Washington, Yuma
Area 4	1.09	Douglas, Eagle, Pitkin

Example: The monthly premium for a 32 year old, non-smoking resident of Denver County is: \$200.94 (\$197 X 1.02).