

### Application Instructions for the New Hampshire Health Plan

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Jamie Stein, HealthNH.com for review along with the completed application. If you do not have access to a fax machine, send the completed application to Jamie Stein, HealthNH.com along with the required first month's payment. \*IMPORTANT - Original application and payment must be mailed to HealthNH.com.

### HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Indicate enrollment type and premium amount.
- Sign and date the application.

### IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Mail completed applications to:

**Jamie Stein, HealthNH.com**  
**Attn: New Enrollment**  
**379 Amherst Street**  
**Suite 340**  
**Nashua, NH 03063**

Jamie Stein, HealthNH.com will review your application for completeness and accuracy before we submit it to the New Hampshire Health Plan for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at (603) 791-4585 or e-mail us at [jamie@healthNH.com](mailto:jamie@healthNH.com).



**FAX COVER LETTER**

(Please ignore this form if you do not have access to a fax machine.)

**\*\*Please FAX this cover letter with the completed application to:**

**Jamie Stein, HealthNH.com**

**FAX# 1-866-730-4025**

Dear Jamie Stein, HealthNH.com,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name \_\_\_\_\_

E-mail \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Please contact me at this phone number \_\_\_\_\_ after you have reviewed my application for completeness and accuracy.

I will contact Jamie Stein, HealthNH.com at (603) 791-4585 to verify receipt of my application.

**\*\*I understand that Jamie Stein, HealthNH.com will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original, signed application and premium payment must still be mailed to Jamie Stein, HealthNH.com. :

**Jamie Stein, HealthNH.com  
Attn: New Enrollment  
379 Amherst Street  
Suite 340  
Nashua, NH 03063**

I will send the original, signed application and premium payment, as soon as I have been contacted by Jamie Stein, HealthNH.com with confirmation that my application has been received by fax and reviewed for completeness.



- A. Are you covered by or eligible for Medicare, Medicaid or Title XXI (NH Healthy Kids)?  Yes  No
- B. Do you have other health insurance coverage that you do not intend to terminate?  Yes  No  
If Yes, state name of company \_\_\_\_\_
- C. Are you eligible for health coverage through your employer or the employer of your spouse or parent?  Yes  No
- Please Note: If the answer is "Yes" to any of the above questions A-C, you are not eligible. No benefits are payable under this policy for any period under which a policy with a prior effective date remains in force.**

Other Coverage Information

During the past two years, have you been covered under another health plan (Major Medical, Major Hospital or HMO) with another company? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide details below:					
Name	Company Name	Policy/Certificate #	Issue Date	Paid-To Date	Type of Coverage:
					<input type="checkbox"/> Major Med <input type="checkbox"/> Major Hosp <input type="checkbox"/> HMO
					List Deductible, Maximum Amount, Benefits, etc.

**Please Note:** The policy applied for will not pay benefits for the treatment of certain preexisting conditions. Refer to the Preexisting Condition Limitation provision of the policy. In determining whether a preexisting condition limitation applies, we will credit the time you were previously covered under Creditable Coverage if the Creditable Coverage was continuous (with no break in coverage over 62 days) to a date not more than 63 days prior to receipt of the application. **To get credit toward satisfaction of the preexisting condition period, you must submit certificate(s) or other evidence of all prior Creditable Coverage.**

I have received the appropriate Outline of Coverage.

I represent that my answers and statements on this application are true and complete to the best of my knowledge. I understand that if they are not, my policy may not be valid and I may be subject to prosecution for insurance fraud. I understand that all hospitalizations and certain other procedures as specified in my policy must be precertified or benefits will be reduced. I authorize providers of health care to furnish the Administrator with medical information to the extent necessary for processing this application or claims.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Premium payments will be required on a monthly basis due on the first of each month.**

- A check made payable to NHHP for the first monthly premium is submitted with this application.
- A New Hampshire Health Plan Residency Affidavit is submitted with this application.

If you consulted an Agent or Broker regarding this coverage, please have the Agent or Broker complete this section.

<b>AGENT/BROKER USE ONLY</b> (Please Print) Under penalties of perjury, I declare that I am aware of no information contrary to the answers and statements on this application and the New Hampshire Health Plan Residency Affidavit submitted herewith.					
Printed Name <u>Jamie Stein</u>		Telephone Number <u>(603) 791-4585</u>			
(Optional) Pay My Commission To _____					
Street Address <u>379 Amherst St., Ste 340</u>		City <u>Nashua</u>		State <u>NH</u> Zip + 4 <u>03063</u>	
Signature _____		Date _____		Tax ID or SS# _____	
<b>OFFICIAL USE ONLY</b>					
Group No. _____		Dept. No. _____		Effective Date _____	
Approved _____		Date _____		Rejected _____ Date _____	

**IMPORTANT NOTICE:** Any person who supplies false information in this application or in any application, claim or other matter with respect to the New Hampshire Health Plan (or who assists or encourages any other person to do so), may be subject to prosecution for insurance fraud. Penalties may include fines, license suspension or revocation, and imprisonment.



**Residency Affidavit**

1. Under penalty of perjury, I declare that I am a resident of the State of New Hampshire as defined in paragraph (3) below. I understand that if I falsely claim to be a resident of the State of New Hampshire, I am subject to prosecution, imprisonment of up to one year, a fine of up to \$2,000 and the denial of any claim under the insurance policy for which I am applying.
2. I also understand that this statement will be relied upon in connection with future renewals of the insurance policy for which I am applying and the payment of claims, and that it is my responsibility to inform the New Hampshire Health Plan when I cease to be a New Hampshire resident and that I will be subject to the penalties listed above if I fail to do so.
3. A resident is a person who maintains his or her true, fixed and permanent residence within the State of New Hampshire, does not claim a residence in any other state for any purpose and who has, through all of his or her actions, demonstrated a current intent to designate that the permanent residence is his or her principal place of physical presence for the indefinite future to the exclusion of all others.
4. The permanent residence referred to above is located at

\_\_\_\_\_

*street address (not P.O. Box)*

\_\_\_\_\_, New Hampshire \_\_\_\_\_

*city or town* *zip*

5. I understand that I may be asked to file an updated affidavit with New Hampshire Health Plan from time to time and other confirmatory proof of residence (e.g., rent receipts, mortgage payments, and utility bills). I will cooperate when asked to do so.

I, the applicant, have read the above and understand the penalties that may apply if I falsely claim to be a New Hampshire resident.

Date: \_\_\_\_\_ Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_

**For applicants under the age of 18:** I am the  custodial parent /  legal guardian of the applicant. Under penalties of perjury, I declare that the above statements of or on behalf of the applicant are true.

Date: \_\_\_\_\_ Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_

My residence is: \_\_\_\_\_

*street address (not P.O. Box)*

\_\_\_\_\_, \_\_\_\_\_

*city or town* *state* *zip*

My telephone: home: \_\_\_\_\_ work: \_\_\_\_\_

*area code & number* *area code & number*



**Non-Tobacco User Affidavit**

Under penalty of perjury, I declare that I neither (i) presently smoke or use tobacco products, nor (ii) have smoked or used tobacco products at any time during the 12 months immediately preceding the date of this affidavit. I understand that if I falsely claim the non-tobacco user discount on my application for insurance, I am subject to prosecution, imprisonment of up to one year, a fine of up to \$2,000, an obligation to pay the additional premium required of tobacco users and the denial of any claim under the insurance policy for which I am applying.

“Smoke or use tobacco products” for purposes of this affidavit means any use of cigarettes, pipes, cigars or any other tobacco products regardless of the number of times, frequency or method of use.

I, the applicant, have read the above and understand the penalties that may apply if my statements are false.

Date: \_\_\_\_\_ Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_

**For applicants under the age of 18:** I am the  custodial parent /  legal guardian of the applicant. Under penalties of perjury, I declare that the above statements of or on behalf of the applicant are true.

Date: \_\_\_\_\_ Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_