

**Application Checklist: Important!** Use this to make sure you send us a complete application.

An incomplete application may delay your enrollment if you qualify. **Note:** Do not send this checklist with your application. When you see this arrow ►, it means you may have to send supporting documents.

- You have reviewed the PCIP and MRMIP comparison charts, which provide information about eligibility, benefits, and costs.
  - You have answered all questions on the application.
  - Send these documents with your application:
    - **For PCIP**, include a copy of **one** of these:
      - A denial letter from individual (not group) health coverage received in the last 12 months
      - A letter dated within the last 12 months from a licensed doctor, physician assistant or nurse practitioner stating the individual has or used to have a medical condition, disability, or illness
      - An offer letter of individual (not group) health coverage with premiums that are **higher than the MRMIP PPO rate** based on the area where you live
      - A Certificate of Creditable Coverage letter issued by PCIP from another state or Federally administered PCIP program, (response on page A3 of application)
    - **For PCIP**, include a copy of **one** of these:
      - Certificate of U.S. Citizenship
      - Certificate of U.S. Naturalization
      - U.S. birth certificate
      - U.S. passport
      - Other proof of citizenship
      - Proof of immigration status (Send documents that are not expired. Include copies of both front and back.)  
For a list of acceptable immigration documents, go to [www.pcip.ca.gov](http://www.pcip.ca.gov). Then click on the "Frequently Asked Questions" link on the website. Or, call us if you need assistance!
    - **If you choose MRMIP**, include a copy of **one** of these:
      - A denial letter from individual (not group) health coverage received in the last 12 months
      - An offer letter of individual (not group) health coverage with premiums that are **higher than your first MRMIP plan choice** received in the last 12 months
      - A termination letter from a health plan, health insurance company or employer plan for reasons other than fraud or non-payment of premiums received in the last 12 months
  - If you choose MRMIP and:**
    - **you are applying for deferred enrollment** because you believe you qualify but currently have health coverage. Include a copy of a letter from the employer or insurance company you have now, telling us when the insurance coverage will end.
    - **you currently have Medicare Part A and Part B because of end-stage renal disease.** Include a copy of the approval letter from Medicare.
    - **you want to waive part or all of the waiting or exclusion period.** Include a copy of proof of any insurance coverage that you had before.
    - **you have a dependent child who is over 23 years old.** Send a doctor's letter with the application for each child over 23 stating that the person cannot work because of a continuous physical or mental disability that started before age 23. The dependent child cannot be married.
  - Sign the application.
  - Write a check for one month's premium for the program you are interested in. Make the check payable to the **Managed Risk Medical Insurance Board (MRMIB)**. See pages 8–13 for the programs' monthly premiums by region.
  - Mail the application with your check and all required documents to:  
California Pre-Existing Condition Insurance Plan, P.O. Box 537032, Sacramento, CA 95853-7032
- Insurance Agents/Brokers or Certified Application Assistants:** Complete **all applicable** boxes at the bottom of the application on page A4 to request and receive payment.

Section 1101 of the Patient Protection and Affordable Care Act, Public Law 111-148 and Insurance Code Sections 12739.52(e), 12711(a), authorizes the programs to collect and maintain the information solicited in this application.

For PCIP questions, call **1-877-428-5060**  
Monday through Friday 8:00 AM – 8:00 PM, Saturday 8:00 AM – 5:00 PM  
or visit [www.pcip.ca.gov](http://www.pcip.ca.gov).

For MRMIP questions, call **1-800-289-6574**  
Monday through Friday 8:30 AM – 7:00 PM  
or visit [www.mrmib.ca.gov](http://www.mrmib.ca.gov).

## Important Notices and Declarations

### PCIP and MRMIP Declarations

- I understand that it is my responsibility to inform PCIP of any health coverage I get in the future or if I move out of California, so that I can be disenrolled.
- I understand that, if I voluntarily disenroll from PCIP or if I am disenrolled involuntarily (for example, for failure to pay my premiums on time), I may not re-qualify for enrollment until at least 6 months after my coverage ends.
- I understand that my application and enrollment information may be shared with other Federal and State government agencies for purposes of establishing PCIP eligibility.
- I understand that my application must be reviewed to determine whether or not I qualify for coverage.
- I understand that, if my application is approved, the effective date of coverage will be determined according to applicable laws and regulations and I will be informed in writing of the effective date of coverage.
- I understand that the MRMIP health plan dispute resolution process may include binding arbitration, rather than a court trial to resolve any claim. This includes a claim for malpractice asserted by me, my enrolled dependents, heirs, personal representatives, **or** someone with a relation to us against the participating health plan or against the employees, partners or agents of the participating health plan.
- I understand that MRMIP's Contra Costa Health Plan DOES NOT require binding arbitration.
- I understand that MRMIP's Anthem Blue Cross and Kaiser Permanente Health Plans DO require binding arbitration of disputes INCLUDING malpractice, so long as the disputes are beyond the jurisdictional limit of the small claims court. This does not include disputes with the program about which benefits are covered.
- I understand that if I do not provide all the necessary information requested to process the application, the application will be denied or returned as incomplete.
- I declare that, within the last 6 months, I have not had health coverage prior to the date I am asking for coverage in the PCIP.
- I declare that all individuals listed on this application are residents of the State of California.
- I declare and understand that making a monthly premium payment does not mean that I am accepted by, or, if accepted, immediately enrolled into, the programs.
- I declare that no person listed on this application and applying for MRMIP is eligible for both Medicare Parts A and Part B, unless they are solely eligible because of end-stage renal disease.
- I declare that no person listed on this application and applying for PCIP is enrolled in Medicare Parts A and B.
- I declare that all individuals listed on this application will abide by all rules of program participation.
- I declare that no person listed on this application and applying for current or deferred enrollment into MRMIP is currently eligible to purchase any continuation of employer health benefits under the provisions of 29 U.S. Code 1161 et seq. (COBRA), **or** under the provisions of Insurance Code Sections 10128.50 et seq. and Health and Safety Code Sections 1366.20 et seq. (Cal-COBRA). These are laws which allow people to buy into their employer's health insurance for up to 36 consecutive months after they leave their employment.
- I declare that no person listed on this application and applying for PCIP is enrolled in COBRA or Cal-COBRA.
- I declare that no person listed on this application, and applying for coverage through the MRMIP, was terminated within the last 12 months from a "Post-MRMIP Guaranteed Issue Pilot Program" as a result of non-payment of premiums, a request to disenroll voluntarily, or fraud. A "Post MRMIP Guaranteed Issue Pilot Program" is a health plan in which an individual had an opportunity to enroll between September 1, 2003 and December 31, 2007 as a result of being disenrolled from MRMIP after 36 consecutive months of enrollment.
- I declare that I have read and understand the information on this Application and agree to these Notices and Declarations.

#### Access to Your Records

You have the right to access records maintained by the Managed Risk Medical Insurance Board that contain your personal information. To do so, contact:

Managed Risk Medical Insurance Board  
Attn: HIPAA Coordinator  
P.O. Box 2769  
Sacramento, CA 95812-2769  
(916) 324-4695