

**THE HEALTH PLAN  
FEDERALLY ELIGIBLE INDIVIDUAL  
PRE-ENROLLMENT QUESTIONNAIRE**

In order for The Health Plan to determine if you are an "eligible" individual for one of our *Federally Eligible Plans*, we ask that you take a few moments to answer the following questions.

1. Were you recently covered (within the past 63 days) by employer sponsored group health insurance, governmental or church plan? Yes  No

If yes, which one were you covered by:

Group Health Plan     Governmental Plan     Church Plan

Name of Plan \_\_\_\_\_ Date Coverage Terminated \_\_\_\_\_

2. Are you currently eligible for:
- |                     |                              |                             |
|---------------------|------------------------------|-----------------------------|
| Group Coverage      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Medicare A and/or B | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Medicaid            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Other Coverage      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If yes, name & type of other coverage: \_\_\_\_\_

3. Were you eligible for COBRA or State continuation coverage when you lost your group coverage? Yes  No

If yes, did you elect the continuation coverage? Yes  No

If yes, has your continuation coverage exhausted? Yes  No

If yes, when did it exhaust? Date \_\_\_\_\_

If no, when does it exhaust? Date \_\_\_\_\_

4. Did loss of your most recent coverage occur due to non-payment of premiums or fraud? Yes  No

Name (Print) \_\_\_\_\_ Address \_\_\_\_\_

Phone # \_\_\_\_\_ Email Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please attach a copy of your "Certificate of Coverage" from your previous carrier and this Questionnaire to the Enrollment Form and mail to The Health Plan. We will notify you in writing or by email as to whether or not you have met the Federal Eligibility Guidelines. **Please do not include any money at this time.****

***Insurance Fraud Warning***

Pursuant to Ohio Revised Code Section 3999.21, "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

