Insure Oklahoma Subscriber Application

Questions? Call us toll-free at 1-888-365-3742

*This application can be filled in electronically then printed , or printed then filled in by hand using blue or black ink. Enter the required information for **ALL** blanks. Enter "none" or "NA" if you don't have any information for a line.*

A Applicant Information

Applicant Information

Legal Name (Last, first, middle initial) | **County of residence**

Home/Street address (cannot be a P.O. box) | **City** | **State** | **Zip Code**

Mailing address (if different) | **City** | **State** | **Zip Code**

Phone number (with area code)

☐ Home ☐ Work ☐ Relative ☐ Neighbor ☐ Cell ☐ Other
What type of phone number did you provide? (check one)

Email Address:

Date of birth

Gender ☐ Female ☐ Male

Hispanic? ☐ Yes ☐ No

U.S. Citizen? ☐ Yes ☐ No

Race? ☐ Asian ☐ African American ☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Social Security Number | **Alien Registration or Admission #** | **US Entry Date listed on card**

What language do you speak? ☐ English ☐ Spanish

What language do you read/write? ☐ English ☐ Spanish

On or eligible for Medicare? ☐ Yes ☐ No

On any SoonerCare program? ☐ Yes ☐ No

Are you/were you enrolled in a private health insurance program in the last 6 months that covers inpatient, outpatient, medical and pharmacy? ☐ Yes ☐ No

Primary Employment status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Not Employed ☐ Unemployed, Collecting Unemployment Benefits

Are you a worker with a disability? ☐ Yes ☐ No

Employer/ Business Name | **Employer FEIN (required)**

Employer phone number | Total # employees | **Hire Date**

Does Employer Offer Health Insurance? ☐ Yes ☐ No

Applying for Insure Oklahoma? ☐ **Yes** ☐ **No** **If yes, complete the following:**

If you are applying for **Employer Sponsored Insurance**, complete following information:

Employer ID# | Health Plan ID# | See PIN letter for Health Plan ID#. Select the H number you are enrolled in.

If you are applying for the **Individual Plan**, you must enter the **ID**s for your 3 Primary Care Provider choices below:

1st Choice | 2nd Choice | 3rd Choice

If you are a working disabled individual, send a copy of the Ticket-To-Work with your application.

For assistance filling out this application call the Helpline at 1-888-365-3742

B Income for Primary Applicant

Job One Gross Paycheck .00 ☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly

Hours Worked Per Week **Hourly Wage** $

Job Two Gross Paycheck .00 ☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly

Hours Worked Per Week **Hourly Wage** $

Other Income Source List:	How Much Money	How Often Received
Unemployment Compensation	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
Veteran's Benefits (VA)	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
State Disability Payment (SSI)	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
SSA	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
Worker's Compensation	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
Other-See Income Fact Sheet	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly

Do you have any Self-Employment income? ☐ **Yes** ☐ **No**

List all businesses that you are a owner or part owner of.

Please list the FEIN numbers 1 2 3

(Use separate paper for more than three FEIN numbers)

1. After you have completed all previous sections of this application, **check the box**, **sign and date Section G and send in a copy of the most recent year's tax return (i.e. 1040, 1040EZ, 1040A) along with all schedules, attachments, including K-1s, W2s and all business taxes.**
2. **If you are married and filing separately, you must submit both spouses' taxes.**
3. Additionally, include **copies of your two most recent pay stubs** from all employers for applicant and spouse.

If your taxes do not reflect your current income, please explain in the box below.

C Spouse Information

Spouse Information

Legal Name (Last, first, middle initial) | County of residence

Home/Street address (cannot be a P.O. box) | **City** | **State** | **Zip Code**

Mailing address (if different) | **City** | **State** | **Zip Code**

Phone number (with area code)

☐ Home ☐ Work ☐ Relative ☐ Neighbor ☐ Cell ☐ Other
What type of phone number did you provide? (check one)

Email Address

Date of birth

Gender ☐ Female ☐ Male

Hispanic? ☐ Yes ☐ No

U.S. Citizen? ☐ Yes ☐ No

Race? ☐ Asian ☐ African American ☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Social Security Number | **Alien Registration or Admission #** | **US Entry Date listed on card**

What language do you speak? ☐ English ☐ Spanish

What language do you read/write? ☐ English ☐ Spanish

On or eligible for Medicare? ☐ Yes ☐ No

On any SoonerCare program? ☐ Yes ☐ No

Are you/were you enrolled in a private health insurance program in the last 6 months that covers inpatient, outpatient, medical and pharmacy? ☐ Yes ☐ No

Primary Employment status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Not Employed ☐ Unemployed, Collecting Unemployment Benefits

Are you a worker with a disability? ☐ Yes ☐ No

Employer/ Business Name | **Employer FEIN** (required)

Employer phone number | Total # employees | **Hire Date**

Applying for Insure Oklahoma? ☐ **Yes** ☐ **No**

If you are applying for the **Individual Plan**, you must enter the **ID**s for your 3 Primary Care Provider choices below:

1st Choice | 2nd Choice | 3rd Choice

If you are a working disabled individual, send a copy of the Ticket-To-Work with your application.

For assistance filling out this application call the Helpline at 1-888-365-3742

D Income for Spouse

Job One Gross Paycheck .00 ☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly

Hours Worked Per Week **Hourly Wage** $

Job Two Gross Paycheck .00 ☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly

Hours Worked Per Week **Hourly Wage** $

Other Income Source List:	How Much Money	How Often Received
Unemployment Compensation	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
Veteran's Benefits (VA)	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
State Disability Payment (SSI)	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
SSA	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
Worker's Compensation	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
Other-See Income Fact Sheet	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly

Do you have any Self-Employment income? ☐ **Yes** ☐ **No**

List all businesses that you are a owner or part owner of.

Please list the FEIN numbers 1 2 3

(Use separate paper for more than three FEIN numbers)

1. After you have completed all previous sections of this application, **check the box**, **sign and date Section G and send in a copy of the most recent year's tax return (i.e. 1040, 1040EZ, 1040A) along with all schedules, attachments, including K-1s, W2s and all business taxes.**
2. **If you are married and filing separately, you must submit both spouses' taxes.**
3. Additionally, include **copies of your two most recent pay stubs** from all employers for applicant and spouse.

If your taxes do not reflect your current income, please explain in the box below.

E Dependent Information

Please include children under age 19 who are either your; biological children; step children (only include step children if a biological parent is in the home) ; legally adopted children and/or legally adopted grand children.

Child

Name (Last, first, middle initial) | **Date of birth** | ☐ Male ☐ Female

Social Security Number | **Check Relation** ☐ Not Related ☐ Son/Daughter ☐ Stepchild ☐ Grandchild ☐ Niece/Nephew ☐ Brother/Sister ☐ Cousin

Is this child enrolled in any SoonerCare Program? ☐ Yes ☐ No

Applicant and/or spouse has legal custody of this child? ☐ Yes ☐ No

Race ☐ Asian ☐ American Indian /Alaska Native ☐ Black /African American ☐ Native Hawaiian/Pacific Islander ☐ White

U.S. Citizen? ☐ Yes ☐ No
Hispanic? ☐ Yes ☐ No

Applying for Insure Oklahoma? ☐ **Yes** ☐ **No**

If you are applying for the **Individual Plan**, you must enter the **ID**s for your 3 Primary Care Provider choices below:

1st Choice | 2nd Choice | 3rd Choice

Other Income Source List:	**How Much Money**	**How Often Received**
SSA	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
State Disability Payment (SSI)	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
Child Support	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
Other-See Income Fact Sheet	$ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly

Are you a full-time Oklahoma college student between the ages of 19 and 22? Yes ☐ No ☐

If yes, then please let us know which Oklahoma college this student is attending.

You MUST send us copies of your FAFSA-SAR and class schedule.

You may use more of these sheets as needed for multiple children.

F Dependent Information

Please include children living in the home, under the age of 19 who are either your; biological children; step children (only include step children if a biological parent is in the home); legally adopted children and/or legally adopted grandchildren.

Child

Name (Last, first, middle initial) | **Date of birth** | ☐ Male ☐ Female

Social Security Number

Check Relation ☐ Not Related ☐ Son/Daughter ☐ Stepchild ☐ Grandchild ☐ Niece/Nephew ☐ Brother/Sister ☐ Cousin

Is this child enrolled in any SoonerCare Program? ☐ Yes ☐ No

Applicant and/or spouse has legal custody of this child? ☐ Yes ☐ No

Race ☐ Asian ☐ American Indian /Alaska Native ☐ Black /African American ☐ Native Hawaiian/Pacific Islander ☐ White

U.S. Citizen? ☐ Yes ☐ No

Hispanic? ☐ Yes ☐ No

Applying for Insure Oklahoma? ☐ **Yes** ☐ **No**

If you are applying for the **Individual Plan**, you must enter the **ID**s for your 3 Primary Care Provider choices below:

1st Choice | 2nd Choice | 3rd Choice

Other Income Source List:	**How Much Money**	**How Often Received**
SSA	$ ____ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
State Disability Payment (SSI)	$ ____ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
Child Support	$ ____ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly
Other-See Income Fact Sheet	$ ____ .00	☐ Weekly ☐ Every 2 Weeks ☐ Twice A Month ☐ Monthly

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G Insure Oklahoma Program Participation Agreement Text

By signing this application, I agree to the following statements:

- I am voluntarily choosing to participate in the Insure Oklahoma Program.

- I declare that my family and I are residents of Oklahoma.

- I declare my spouse (if applicable) and I are legally married.

- I authorize Insure Oklahoma to use my and the members of my family's Social Security Number (SSNs). By signing this consent to disclose my SSN, I authorize Insure Oklahoma to use and to disclose my SSN to others if it is necessary to confirm my eligibility.

- I authorize Insure Oklahoma to contact other people and agencies to verify my eligibility for the program.

- I will be responsible for paying the appropriate premiums and out-of-pocket costs including but not limited to copayments.

- I understand that I will not be eligible for traditional SoonerCare programs (Medicaid) or additional state sponsored coverage while enrolled in the Insure Oklahoma Program.

- I understand that If I have children, I am required to help the Oklahoma Department of Human Services (OKDHS) or the Oklahoma Healthcare Authority (OHCA) to identify and locate those absent parents who might be liable for the cost of medical care to the children you are enrolling.

- If in the future I wish to enroll in a SoonerCare program, I may apply at anytime. If accepted, I will no longer be eligible for the Insure Oklahoma Program and will not be refunded premiums or out-of-pocket expenses previously paid.

- The information I give on this form is true and correct to the best of my knowledge. I realize if I give information that is not true OR if I withhold information, I can be lawfully punished for fraud or perjury. I may also have to re-pay the State of Oklahoma for any payments or claims incurred which were paid due to my fraud or error.

☐ **By checking this box, the applicant agrees to the terms and conditions of the program.**

Applicant Signature: _____ Date: _____

When you have completed the Insure Oklahoma Subscriber Application, mail it to:

Insure Oklahoma
PO BOX 54200
Oklahoma City, OK 73154-1200
You may also fax your application to **405-949-9563**

Print Form

Remember to sign and date the application. Always make copies of the documents you are submitting for your own record.