SPECIAL ENROLLMENT REQUEST

You may qualify for a special enrollment period that will allow you to enroll in health insurance outside of Open Enrollment. Please complete the form below for your request to be reviewed.

IMPORTANT: You must start an application prior to submitting this form by clicking on apply now a www.wahealthplanfinder.org. Once the form is received your case will be reviewed and a decision communicated within 14 business days. You request will not be considered for retroactive enrollment determination. This form is only applicable for Qualified Health Plan applicants and does not apply to customers eligible for Washington Apple Health.

Healthplanfinder Application ID #: Today's date: 06/30/2014

PRIMARY APPLICANT'S INFORMATION

Applicant's First Name | Last Name | Middle Initial | Date of Birth

Address | City | Zip | Daytime Telephone Number

Email Address

What is the best way to contact you?

○ Email ◉ Telephone ○ Mail

REASON FOR YOUR REQUEST

Check all boxes that apply

- ☐ Currently have COBRA coverage (must fill out and submit form to Washington Healthplanfinder by July 1)
- ☐ My coverage in the Washington State Insurance Pool has ended
- ☐ My coverage in the federal Pre-existing Condition Insurance Plan is ending
- ☐ My pregnancy-related or medically needy Medicaid coverage is ending
- ☐ I am beginning service in or losing coverage through AmeriCorps, VISTA, or National Civilian Community Corps
  - National Service Personal Identifycation Number | Date of Event
- ☐ My individual plan available outside of the Washington Healthplanfinder Open Enrollment period is up for 2014 coverage renewal

Please explain the reason(s) you are requesting review of your application:

SIGNATURE (REQUIRED)

My signature below is my request for a special enrollment determination made by the Washington Healthplanfinder. The information provided in this form is true and correct, to the best of my knowledge. I understand that this request may be forwarded to the entity with the authority to handle this request if that entity is not the Washington Health Benefit Exchange.

Applicant's Name | Date 06/30/2014

Submit

Alternatively, you can mail this form to:
Washington Healthplanfinder

PO BOX 957
OLYMPIA WA 98507-1757

The Washington Health Benefit Exchange provides equal access to all services.
If you need assistance, an interpreter, or accommodation, please call 1-855-923-4633.