APPLICATION FOR COVERAGE
KENTUCKY ACCESS

P.O. Box 33707
Indianapolis, IN 46203-0707
1.866.405.6145
www.kentuckyaccess.com

Please type or print in black ink. All questions must be answered in complete detail (attach a separate piece of paper if necessary). If you have questions while completing the application, visit our Web site at www.kentuckyaccess.com or call Customer Service at 1.866.405.6145.

SECTION I: PLAN INFORMATION

FOR OFFICE USE ONLY

EFFECTIVE DATE OF COVERAGE: ____ ____ ____

I understand once eligibility is verified, the effective date of coverage will be the later of: 1) The first day of the month following the date application is received, or 2) the following date as requested (not to exceed three months after the month of application) _____.

A

☐ TRADITIONAL ACCESS (Fee for Service – FFS)
- ☐ Single - $400
- ☐ Family - $800
- ☐ Mental Health Rider
- ☐ Prescription Drug Rider

☐ PREMIER ACCESS (Preferred Provider Organization – PPO)

Single	☐ $400	☐ $1,000	☐ $1,500	
Family	☐ $800	☐ $2,000	☐ $3,000	

- ☐ Mental Health Rider
- ☐ Prescription Drug Rider

☐ PREFERRED ACCESS (Preferred Provider Organization – PPO)

Single	☐ $750	☐ $1,500
Family	☐ $1,500	☐ $3,000

- ☐ Mental Health Rider
- ☐ Prescription Drug Rider

SECTION II: APPLICANT INFORMATION

E-MAIL ADDRESS (optional)

B

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			- -

HOME ADDRESS (Both Current and P.O. Box, if applicable)	SEX (check one)	BIRTH DATE: MONTH DAY YEAR	AGE
	☐ Male ☐ Female	/ /	

CITY	STATE	ZIP CODE	COUNTY OF RESIDENCE

HOME TELEPHONE	WORK TELEPHONE	CUSTODIAL PARENT / GUARDIAN IF APPLICANT IS MINOR
( )	( )	

NAME OF CURRENT EMPLOYER	START DATE AT CURRENT EMPLOYER

NAME OF PREVIOUS EMPLOYER	BEGIN DATE OF PREVIOUS EMPLOYER	TERMINATION DATE OF PREVIOUS EMPLOYER
	____/____/____	____/____/____

CHECK THE BOX BY YOUR TOTAL ANNUAL GROSS HOUSEHOLD INCOME:

☐ $0 - $15,000	☐ $ 25,001 - $35,000	☐ $45,001 - $55,000	☐ $65,001 - $75,000
☐ $15,001 - $25,000	☐ $ 35,001 - $45,000	☐ $55,001 - $65,000	☐ $75,001 or more

HAVE YOU BEEN DETERMINED DISABLED BY SOCIAL SECURITY?
☐ YES ☐ NO If YES, The Date Determined Disabled Is _____/_____/_____ (Month / Day / Year) AND provide a copy of your determination letter

HAVE YOU BEEN DETERMINED DISABLED BY THE MEDICAL REVIEW TEAM AT THE CABINET FOR HEALTH AND FAMILY SERVICES?
☐ YES ☐ NO If YES, The Date Determined Disabled Is _____/_____/_____ (Month / Day / Year) AND provide a copy of your determination letter

SECTION III: SPOUSE/DEPENDENT INFORMATION

List spouse / dependents to be covered under this plan. Spouse and dependents must be a federally eligible individual or a resident for 12 months. In addition, a dependent must be: (1) unmarried and under the age of 19, (2) unmarried, under the age of 25, a full-time student at an accredited high school, trade school, college or university, and chiefly dependent upon you for support, OR (3) unmarried, incapable of self-sustaining employment by reason of mental or physical disability, and chiefly dependent upon you for support. A copy of the following for each dependent must accompany your application: 1) Proof of federal or state income tax records for the most recent twelve (12) month tax period, and 2) Letter of verification of full-time student status, or 3) Letter of determination of disability from the Social Security Administration.

C

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			- -

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLE OF SELF-SUSTAINING EMPLOYMENT	SEX (check one)	BIRTH DATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No Due To Mental or Physical Disability	☐ Male ☐ Female	/ /	

D

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			- -

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLE OF SELF-SUSTAINING EMPLOYMENT	SEX (check one)	BIRTH DATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No Due To Mental or Physical Disability	☐ Male ☐ Female	/ /	

E

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			- -

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLE OF SELF-SUSTAINING EMPLOYMENT	SEX (check one)	BIRTH DATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No Due To Mental or Physical Disability	☐ Male ☐ Female	/ /	

SECTION IV: ELIGIBILITY INFORMATION

F

Each Eligibility Category REQUIRES ONE of the following Documentary Proofs of Residency:

1) PROOF OF CURRENT RESIDENCY in the State of Kentucky, which may include one of the following documents: a receipt within 3 months prior to the date of application for rent, mortgage payment, utility bill, or a resident Kentucky income tax return for the most recent 12 month tax period, a copy of your active Kentucky driver's license OR a copy of your active Kentucky personal identification card issued by the clerk of the applicant's county of residence, or
2) PROOF OF 12-MONTH RESIDENCY in the State of Kentucky, which may include one of the following documents: a receipt 12 months prior to date of application AND another receipt within the last 3 months prior to the date of application for rent, mortgage payment, utility bill, or a resident Kentucky income tax return for the most recent 12 month tax period, a copy of your Kentucky driver's license issued at least 12 months ago OR a copy of your Kentucky personal identification card issued by the clerk of the applicant's county of residence dated 12 months or more prior to date of application for Kentucky Access.

PLEASE CHECK AND INITIAL EACH ELIGIBLITY CATEGORY DESCRIBED IN F-1 TO F-5 UNDER WHICH YOU ARE APPLYING

F-1 ☐ FEDERALLY ELIGIBLE

I am federally eligible according to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 because I have had health care coverage for at least 18 months prior to the effective date of coverage with no lapse in coverage of at least 63 days. My most recent coverage was under a group plan and I have exhausted my benefits under Consolidated Omnibus Budget Reconciliation Act (COBRA); I'm not eligible under another group health plan offered by my employer or as a dependent for coverage through my spouse, parent, or guardian; My most recent coverage was not canceled because I failed to pay my premiums, or failed to pay my premiums in a timely manner, or committed fraud; I am not eligible for Medicare or Medicaid; and I did not accept a conversion policy or a short-term limited duration policy after my group, COBRA, or state continuation coverage ended.
NOTE: If your employer failed to offer you benefits under COBRA, please indicate below. The fact that COBRA was never offered will not prevent you from being considered federally eligible under HIPAA.

Name of the employer that provided your last month of coverage: _____

The date you terminated from the employer that provided your last month of coverage: _____ / _____ / _____ (Month / Day / Year)

Reason for termination of coverage:

☐ Failure to pay premiums ☐ For Fraudulent Reasons ☐ Other (Explain) _____

Did your former employer sponsor a health insurance plan for any of its employees? ☐ YES ☐ NO

Which of the following types of organizations was your former employer?

☐ Company ☐ Governmental Entity
☐ Church ☐ Other (Explain) _____

At the time you terminated employment with your former employer, did your former employer offer you an opportunity to continue your group insurance coverage (with you paying the premium) under COBRA or state continuation coverage? ☐ YES ☐ NO

Are you still employed by your current employer but your employer is terminating the group's coverage for all the employees? ☐ YES ☐ NO

Is your employer terminating your company's group coverage and offering to purchase individual policies for all of its employees? ☐ YES ☐ NO

During the past 21 months, have you accepted conversion or short-term limited duration coverage? ☐ YES ☐ NO

Does your spouse have group coverage with his or her employer? If YES, please explain why you will not be added to your spouse's coverage: _____ ☐ YES ☐ NO

Did you apply for individual insurance coverage with another insurance company prior to submitting this application to KY Access? ☐ YES ☐ NO

If YES, was this application rejected? Please enclose a copy of the rejection notice ☐ YES ☐ NO

Date you made application with this insurance company: _____

REQUIRED DOCUMENTATION (Must Accompany This Application):

1) A copy of the Certificate of Health Plan Coverage or any other evidence of prior health insurance coverage provided by your previous insurance carrier / employer or other evidence of medical coverage. Examples of other types of documentation include letters from prior insurers and payment receipts.
2) Proof of current residency in the State of Kentucky for applicant listed in Section II and any persons listed in Section III, Spouse/Dependent Information. (See Section F for required documentation)

_____ Initial Here

F-2 ☐ GUARANTEED ACCEPTANCE PROGRAM (GAP)

I have previously received health insurance coverage under the Guaranteed Acceptance Program.

REQUIRED DOCUMENTATION (Must Accompany This Application):

1) A copy of the notice verifying GAP enrollment from Anthem or Humana.
2) Proof of current residency in the State of Kentucky for applicant listed in Section II and any persons listed in Section III, Spouse/Dependent Information. (See Section F for required documentation)

_____ Initial Here

F-3 ☐ REJECTION FOR HEALTH COVERAGE

I received notification of rejection from a health insurer for individual health coverage substantially similar to the coverage offered by Kentucky Access.

Date your last health coverage ended: _____

Date you made application with the insurer that issued the rejection: _____

If your health coverage ended within 90 days of the date of application, have you been offered a Conversion Policy? ☐ Yes ☐ No

REQUIRED DOCUMENTATION (Must Accompany This Application):

1) A copy of the letter of rejection from the health insurer that is dated within 90 days of the effective date of KY Access coverage.

2) Proof of 12-month residency in the State of Kentucky for applicant listed in Section II and any persons listed in Section III, Spouse/Dependent Information. (See Section F for required documentation)

_____ Initial Here

F-4 ☐ PREMIUM RATE HIGHER THAN KENTUCKY ACCESS

I received a premium rate for individual health insurance coverage substantially similar to the coverage offered by Kentucky Access either applied for or in force exceeding the premium rate for coverage by Kentucky Access.

REQUIRED DOCUMENTATION (Must Accompany This Application):

1) A copy of the premium notice for the policy that is dated within 90 days of the effective date of KY Access coverage.

2) Proof of 12-month residency in the State of Kentucky for applicant listed in Section II and any persons listed in Section III, Spouse/Dependent Information. (See Section F for required documentation)

_____ Initial Here

F-5 ☐ DIAGNOSED WITH A HIGH COST MEDICAL CONDITION

I have been diagnosed with one of the medical conditions listed below (please circle all conditions that apply).

Date your last health coverage ended: _____

If your health coverage ended within 90 days of the date of application, have you been offered a Conversion Policy? ☐ Yes ☐ No

Did you apply for individual insurance coverage with another Insurance Company prior to submitting this application to KY Access? ☐ YES ☐ NO

If YES, was this application rejected? Please enclose a copy of the rejection notice ☐ YES ☐ NO

Date you made application with this insurance company: _____

REQUIRED DOCUMENTATION (Must Accompany This Application):

1) A letter from your Physician stating your diagnosis of one of the medical conditions listed below.

AIDS	Juvenile Diabetes (Type I)	Quadriplegia
Angina Pectoris	Leukemia	Stroke
Ascites	Metastatic Cancer	Syringomyelia
Chemical Dependency	Motor or Sensory Aphasia	Wilson's Disease
Cirrhosis of the Liver	Multiple Sclerosis	Chronic Renal Failure
Coronary Insufficiency	Muscular Dystrophy	Malignant Neoplasm of the Trachea
Coronary Occlusion	Myasthenia Gravis	Malignant Neoplasm of the Bronchus
Cystic Fibrosis	Myotonia	Malignant Neoplasm of the Lung
Friedreich's Ataxia	Open Heart Surgery	Malignant Neoplasm of the Colon
Hemophilia	Parkinson's Disease	Short Gestation Period for a Newborn Child
Hodgkin Disease	Polycystic Kidney	Low Birth Weight of a Newborn Child
Huntington's Chorea	Psychotic Disorders	

_____ Initial Here

2) Proof of 12-month residency in the State of Kentucky for applicant listed in Section II and any persons listed in Section III, Spouse/Dependent Information. (See Section F for required documentation)

SECTION V: MEDICARE / MEDICAID COVERAGE

If any person named on this application is enrolled in Medicare or Medicaid then that person would not be eligible for coverage through Kentucky Access.

G ☐ YES ☐ NO Is any person named on this application currently enrolled in Medicare?

☐ YES ☐ NO Will any person named on this application be eligible for Medicare in the four-month period following date of application?

If YES, name of person (s): _____ _____

Identification Number (s): _____ _____

Effective Date(s): Part A _____ Part A _____

Part B: _____ Part B: _____

☐ YES ☐ NO Are you currently eligible or will you be eligible in the future for premium-free Medicare Part A? If "NO", please tell us the amount of premium you pay for Medicare Part A only: _____

H ☐ YES ☐ NO Is any person named on this application currently enrolled in Medicaid?

☐ YES ☐ NO Will any person named on this application be eligible for Medicaid on an ongoing bases following date of application?

If YES, name of person (s): _____ _____

Identification Number (s): _____ _____

Effective Date(s): _____ _____

SECTION VI: OTHER COVERAGE

I ☐ YES ☐ NO Do you or any person named on this application have any other **medical** or **hospital** insurance?

If YES:

Name of person (s): _____ _____

Insurance Company Name: _____ _____

Insurance Company Phone: _____ _____

TYPE OF COVERAGE:

Is your current coverage GROUP? ☐ YES ☐ NO

(Month / Day / Year)

The date you terminated or will be terminated from the company that is providing your group coverage: ____ / ____ / ____

Are you currently covered by COBRA or state continuation coverage? ☐ YES ☐ NO

If YES, and if you are approved for coverage with Kentucky Access, how many months will you have been on COBRA or state continuation coverage by the time you start coverage with Kentucky Access? _____

Is your current coverage INDIVIDUAL? ☐ YES ☐ NO

If YES, check the box that best describes your coverage:

☐ Comprehensive Major Medical (CMM) ☐ Limited (e.g., "hospital-only" coverage or "cancer-only" coverage) ☐ Union plan
☐ Professional or trade association plan ☐ Student health plan ☐ Another State health benefits risk pool (a plan like Kentucky Access)
☐ Other (Explain): _____

Is it your intent to replace your current coverage with Kentucky Access coverage? ☐ YES ☐ NO

If YES, please explain the reason for replacement: _____

If NO:

Does your current employer offer health coverage to any of its employees? ☐ YES ☐ NO

If YES, has your employer offered you an opportunity to participate in the employer-sponsored health plan? ☐ YES ☐ NO

If YES, why aren't you participating in the employer-sponsored plan?

☐ I have waived my employer-sponsored coverage
☐ I've been directed to apply to Kentucky Access (please explain under "Other")
☐ Other (Explain) _____

If you are married, is your spouse employed? ☐ YES ☐ NO

If YES, does your spouse's employer offer health insurance to its employees? ☐ YES ☐ NO

If YES, are you currently enrolled in your spouse's employer's plan? ☐ YES ☐ NO

If NO, why not? ☐ Missed enrollment ☐ Too expensive ☐ Spouse waived coverage ☐ Not available for dependents
☐ Other, please explain: _____

☐ YES ☐ NO Are you under age 18?

If YES, is your parent or guardian employed? ☐ YES ☐ NO

If YES, does their employer offer health insurance to its employees? ☐ YES ☐ NO

If YES, are you currently enrolled in your parent or guardian's employer's plan? ☐ YES ☐ NO

If NO, why not? ☐ Missed enrollment ☐ Too expensive ☐ Spouse waived coverage ☐ Not available for dependents
☐ Other, please explain: _____

SECTION VII: PREMIUM PROVISION

J Will any **PART** or **ALL** of the premium used to purchase this coverage be provided by:

A Church / Church affiliated group? ☐ YES ☐ NO
A division of government, either county, city, state, federal or other? ☐ YES ☐ NO
A Government agency, such as Medicaid, Medicare, Public Health Department or other programs such as indigent programs? ☐ YES ☐ NO
A public or private foundation? ☐ YES ☐ NO
A health care provider? ☐ YES ☐ NO
An employer of the individual? ☐ YES ☐ NO
A person other than the individual's parent, adult child, or guardian? ☐ YES ☐ NO
☐ YES ☐ NO

Other (Explain) _____

If you answered "YES" to any questions above, please list the following:

Name of Organization: _____

Address of Organization: _____

_____

Phone Number of Organization: _____

SECTION VIII: PRE-EXISTING CONDITIONS PROVISION

K

Benefits under any Kentucky Access Plan (including spouse/dependent) will not be payable for a pre-existing condition (injury or sickness) for 12 months following the effective date of coverage if medical advice, diagnosis, care or treatment (including any prescription medications) for the pre-existing injury or sickness was recommended or received within a period of six months before the effective date of coverage. The 12-month period may be reduced by the number of months for which you have creditable coverage. A copy of the Certificate of Health Plan Coverage period by your previous health insurance carrier / employer or other evidence of medical coverage must be sent along with this application.

WAIVER BENEFIT: You and any person named on this application may be eligible for a waiver of the pre-existing condition waiting period if you are an eligible individual. A copy of the Certificate of Health Plan Coverage provided by your previous health insurance carrier / employer or other evidence of medical coverage must be sent along with this application.

PLEASE ANSWER THE FOLLOWING QUESTIONS

☐ YES ☐ NO Have you or any person named on this application received medical advice, care or treatment including any prescription medications in the six months preceding the effective date of coverage.

If YES, please provide Medical Information for each person named on this application (attach an additional sheet of paper if necessary).

APPLICANT NAME	PHYSICIAN NAME	DIAGNOSIS	TREATMENT	DATES OF TREATMENT	DATES OF HOSPITALIZATION	MEDICATION	DATES BEGAN TAKING MEDICATION

SECTION IX: AGENT INFORMATION

If an insurance agent referred you to Kentucky Access, please fill out this section or have the agent fill out this section.

I certify by my signature that follows, that I have explained eligibility provisions to the applicant and assure that I have reviewed the application AFTER it was completed; the application is complete and accurate; and I have complied with KRS 304.17A-150 (3) [Unfair Trade Practices]

L

AGENT OR BROKER NAME			KENTUCKY INSURANCE LICENSE NO.
BUSINESS OR AGENCY NAME			SOCIAL SECURITY NUMBER OR TAX ID
ADDRESS			TELEPHONE NUMBER – WORK
CITY	STATE	ZIP CODE	TELEPHONE NUMBER – HOME (optional)
MAKE CHECK PAYABLE TO:			
AGENT SIGNATURE:			DATE

SECTION X: PREMIUM PAYMENT

M

PLEASE CHOOSE ONE OF THE PREMIUM PAYMENT OPTIONS BELOW:

☐ MONTHLY – 2 MONTHS PREMIUM DUE WITH APPLICATION.

- ☐ VIA BANK DRAFT (Premium automatically deduct from your bank account). Complete Authorization Form on following page.
- ☐ VIA MAIL (Premium bill sent via U.S. Mail).

☐ QUARTERLY – 3 MONTHS PREMIUM DUE WITH APPLICATION.

☐ SEMI-ANNUALLY – 6 MONTHS PREMIUM DUE WITH APPLICATION.

☐ ANNUALLY – 12 MONTHS PREMIUM DUE WITH APPLICATION.

N USE THE PREMIUM RATE TABLE AND THE WORKSHEET BELOW TO DETERMINE YOUR PREMIUM PAYMENT:

PREMIUM WORKSHEET:	APPLICANT	DEPENDENT 1	DEPENDENT 2
PREMIUM AMOUNT FOR PLAN SELECTED FROM PREMIUM RATE TABLE	A1	B1	C1
PREMIUM AMOUNT FOR PHARMACY RIDER FROM PREMIUM RATE TABLE (optional)	A2	B2	C2
PREMIUM AMOUNT FOR MENTAL HEALTH/SUBSTANCE ABUSE RIDER FROM PREMIUM RATE TABLE (optional)	A3	B3	C3
TOTAL PREMIUM PER APPLICANT AND/OR DEPENDENT	Total Premium A1 + A2 + A3 = A4	Total Premium B1 + B2 + B3 = B4	Total Premium C1 + C2 + C3 = C4
TOTAL PREMIUM PER MONTH			Total Premium/Month = A4 + B4 + C4
INITIAL PREMIUM PAYMENT (2 x TOTAL PREMIUM PER MONTH)			2 x Total Premium Month

PREMIUM AMOUNT ENCLOSED → $, .

FOR OFFICE USE ONLY

$, . PREMIUM PAYMENT

CHECK NUMBER

SECTION XI: DISCLOSURE AUTHORIZATION AND DECLARATION

THE FOLLOWING INFORMATION DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED. PLEASE REVIEW IT CAREFULLY.

I authorize the release of any medical or other information, including but not limited to claims, conditions, and treatment, concerning myself or for any dependents listed herein, by any provider of health services, the Veterans Affairs, pharmacy benefit managers, the Medical Information Bureau, Inc., my employer, insurance company, health maintenance organization or otherwise, to Kentucky Access, Division of the Kentucky Office of Insurance ("Kentucky Access") and its subsidiaries, affiliates, and any administrators, agents or other entity providing services on behalf of Kentucky Access.

This information will be used for treatment, payment or health care purposes which include but are not limited to claims, claims administration; claims adjustment and management; detection, investigation or reporting of actual or potential fraud; misrepresentation or criminal activity; underwriting; policy placement or issuance; loss control; ratemaking and guaranty functions; reimbursement and excess loss insurance; risk management; case management; disease management; quality assurance; quality improvement; performance evaluation; provider credentialing verification; utilization review; peer review activities, actuarial, scientific, medical or public policy research; grievance procedures; internal administration of compliance, managerial and information systems; policyholder service functions; auditing; reporting; database security; administration of consumer disputes and inquiries; external accreditation standards; the replacement of a group benefit plan or workers' compensation policy or program; activities in connection with a sale, merger, transfer or exchange of all or part of a business operating unit; any activity that permits disclosure without authorization pursuant to the federal Health Insurance Portability and Accountability Act privacy rule promulgated by the U.S. Department of Health and Human Services at 45 CFR 160, et. Seq.; disclosure that is required, or is one of the lawful or appropriate methods, to enforce Kentucky Access' rights or the rights of persons engaged in carrying out a transaction or providing a product or service that a consumer requests or authorizes; and any activity otherwise permitted by law, required pursuant to governmental reporting authority, or to comply with legal process.

I understand and agree that Kentucky Access may furnish this information to other entities, which may include insurers, pharmacy benefit managers and governmental agencies. Kentucky Access will advise such entities that such information must be kept confidential to the extent necessary or as otherwise required by law and should not be used for any unlawful purpose. This information includes any records of knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted disease or other communicable diseases contained in such records, including but not limited to, all records of office visits, examination, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider.

I understand that my misstatements or failure to report new medical information prior to approval of my application may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or recession or cancellation of my coverage(s).

Any person who knowingly and with intent to defraud Kentucky Access, or make a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact regarding the material thereto, commits a fraudulent insurance act, which is a crime.

This authorization will be valid form the date signed.

I hereby acknowledge that I have received and fully understand the Application for Kentucky Access and that the information contained in the application may only be used in the administration of Kentucky Access.

I have read or had read to me, all of the above questions and my answers to them and I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge. I understand that any false statement or misrepresentation in the application may result in loss of coverage under the Kentucky Access coverage being applied for.

I understand that, if approved, Kentucky Access coverage is effective in accordance with 806 KAR 17:320, Section 6(1)

O	SIGNATURE OF APPLICANT	DATE: (MONTH DAY YEAR) / /
P	SIGNATURE OF CUSTODIAL PARENT OR GUARDIAN (If applicant is under age 18)	DATE: (MONTH DAY YEAR) / /