



## CDPH PRE-EXISTING CONDITION INSURANCE PLAN PROGRAM APPLICATION



Are you currently enrolled in ADAP?     YES     NO

If Yes, ADAP Client ID Number:

Did you know ADAP pays prescription deductibles and co-payments to eligible recipients for drugs on the ADAP formulary?  
We encourage you to apply. For more information, call (888) 311-7632.

**Applicant Information**

Applicant's Name (First, MI, Last)		Social Security Number*		Mother's Maiden Name	
Home Address (Number, Street, Apt #)	City	County	State	Zip Code	
Mailing Address (if different than home)	City	County	State	Zip Code	
Telephone Number	Email Address		Date of Birth (mm/dd/yyyy)		

**IMPORTANT:** Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH). The information may be used to contact insurance companies, employers, providers of health care services, and state and county agencies to determine the extent of available health insurance and eligibility for insurance assistance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information, contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.

**AUTHORIZATION:** I authorize insurance companies, employers, providers of health care services, and state and county agencies to release of information to CDPH with regard to health insurance premiums and benefits. I authorize payment of refunds to CDPH for premiums paid by the program.

**DECLARATION:** I agree to re-enroll annually and re-certify as required by the program. I agree to inform CDPH of any changes to my eligibility requirements for the program as soon as I am aware of these changes. I certify that the answers I have given in this application and the documents provided are true and correct to the best of my knowledge. I understand that failure to provide accurate information may result in termination of insurance premium assistance.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Policy Holder (if different)

\_\_\_\_\_  
Signature of Policy Holder

\_\_\_\_\_  
Date

**STATE OF CALIFORNIA USE ONLY – AUTHORIZATION TO PAY PREMIUM**

The CDPH Insurance Assistance Section authorizes the payment in the amount indicated below to the Managed Risk Medical Insurance Board for Pre-Existing Condition Insurance Plan (PCIP) Premiums.

Total Payment \$	Payment Period	PCIP Liaison	Authorized Signature	Date
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