Applicant Name _____

SSN# _____

Member ID _____

Effective Date _____

Cancellation Date _____

Individual Plan

New Application or Change in Coverage

You have the option to choose a Consumer Choice of Benefits Health Maintenance Organization healthcare plan that, either in whole or in part, does not provide state-mandated hea196 ra6 (359. 0 8/T. 12..601.78 Td(-)TJETQ0 0 612 792 reW*n

Applicant Name _____

SSN# _____

6. I AM NO LONGER RESIDING OR LIVING IN MY PRIOR HEALTH INSURANCE PLAN'S HMO SERVICE AREA AS OF	DATE
7. AN ERROR OCCURRED IN MY PREVIOUS HEALTH PLAN ENROLLMENT ON	DATE
8. I HAVE ADEQUATELY DEMONSTRATED THAT MY PREVIOUS HEALTH PLAN OR ISSUER SUBSTANTIALLY VIOLATED A MATERIAL PROVISION OF ITS CONTRACT WITH ME, AS OF	DATE
9. I AND/OR MY DEPENDENTS LOST MINIMUM ESSENTIAL COVERAGE DUE TO REASONS OTHER THAN NON-PAYMENT OF PREMIUM OR RESCISSION ON	DATE
10. COURT ORDER	DATE
[redacted]	

Applicant Name _____

SSN# _____

SPOUSE AND/OR DEPENDENT CHILDREN TO BE COVERED/TERMED (dependent children must be under age 26)			
FIRST NAME, MIDDLE INITIAL, LAST NAME			RELATIONSHIP
SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH	
ARE YOU A U.S. CITIZEN? Y N		ARE YOU AN ELIGIBLE NON-CITIZEN? Y N	
*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N IF YES, PLEASE PROVIDE DATE OF LAST USE:			
*MAILING ADDRESS - STREET, CITY, STATE, ZIP IF DIFFERENT THAN ABOVE			COUNTY
PRIMARY PHONE CAN WE SEND YOU TEXT MESSAGES? Y N			
EMAIL ADDRESS			PREFERRED CONTACT METHOD ☐ EMAIL ☐ POSTAL MAIL
PRIMARY CARE PHYSICIAN (FOR HMO ONLY)			
DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) Y N IF "YES," DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:			
OBSTETRICIAN OR GYNECOLOGIST (FOR HMO ONLY)			

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP

SOCIAL SECURITY NUMBER

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☐☐

Applicant Name _____

SSN# _____

Applicant Name _____

SSN# _____

NOTICE TO APPLICANT REGARDING WRITTEN COMMUNICATION BEING DELIVERED ELECTORONICALLY

WRITTEN COMMUNICATION DELIVERED ELECTRONICALLY

☐☐

If you indicate “Yes” in this section and provided an email address in Section A above, you will receive all communications including your plan documents electronically at the email provided. Plan documents may also be viewed and printed anytime, you can find all documents on your Online Account. You can request a paper copy of any written communication by calling Customer Service at the number listed on

Applicant Name _____

SSN# _____

Section B: Applying for Coverage

NOTE: Effective dates are available on the 1st of the month only, unless otherwise required by law. Applications must be received by Community Health Choice Inc. within the defined enrollment period to be accepted.

Has the Primary Applicant, Spouse, or any Dependent Children traveled from another country for the purpose of obtaining insurance coverage for a specific medical treatment or procedure to be performed in the Service Area?

Please circle: Yes / No

PLAN SELECTION	DEDUCTIBLE
☐ **Community Premier Bronze 003**	
☐	
☐	
☐	
☐	
☐	
☐	
☐	
☐	

*Age 18 and over

Applicant Name _____

SSN# _____

Section C: Billing Information

Note:

Do not cancel any current coverage you may have until your application is approved and your new plan is effective.

Please select one of the following options to make arrangements for paying your premium.

BANK DRAFT
Bank Draft includes initial and ongoing payments. Payment will be drafted upon receipt of this application. You must complete the Authorization Agreement below. (Check all that apply)
☐ FIRST MONTH'S PREMIUM
RECURRING MONTHLY OPTIONS: ☐ TOTAL AMOUNT DUE ☐ PREMIUM AMOUNT DUE ☐ OTHER AMOUNT ☐ RECURRING 15th ☐ DRAFT DATE 25th

AUTHORIZATION AGREEMENT

Required for Bank Draft Payments Only

I request and authorize Community Health Choice and/or its designee to obtain pay.u-nc58eW* nBT/TT0 9.96 Tf22.32 529.99 Td**[**

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Applicant Name _____

SSN# _____

Applicant Name _____

SSN# _____

RESPONSIBLE PARTY BILLING NAME AND ADDRESS
If different than applicant name and residential address. If an address is entered in this section, only the billing will be sent to this address; all other correspondence will be sent to the address in Section A, unless requested otherwise.
FIRST NAME, MIDDLE INITIAL, LAST NAME
BILLING ADDRESS STREET, CITY, STATE, ZIP (NO P.O. BOXES)
NAME OF BILL TO PARTY (IF REQUESTING LIST BILL ONLY)

Section D: Other Coverage Information

OTHER COVERAGE INFORMATION

DOES ANY PERSON APPLYING FOR COVERAGE CURRENTLY HAVE HEALTH OR MAJOR MEDICAL COVERAGE WITH ANY OTHER INSURER, EITHER AS A PRIMARY INSURED, SPOUSE OR AS A DEPENDENT?

☐ ☐

☐ ☐

*Age 18 and over

Applicant Name _____

SSN# _____

Section E: Required Signatures

Acknowledgments: The applicant, to the best

Applicant Name _____

SSN# _____

Signatures: I acknowledge receipt of the Explanation of Coverage and I certify that:

1. Premiums are paid by me as a personal expense
2. My employer is not contributing to any part of the premium, either directly or through reimbursement.
3. Since my employer does

☐ ☐

LANGUAGE ASSISTANCE

Community Health Choice, Inc. is required by federal law to provide the following information.

NON-DISCRIMINATION STATEMENT (MARKETPLACE)

Discrimination is Against the Law

Community Health Choice, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Community Health Choice, Inc. does not exclude or treat people differently because of race, color, national origin, age, disability or sex.

Community Health Choice, Inc.:

- Provides free aids and services to people with disabilities so that they can communicate effectively with us, such as:
  - Qualified sign-language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

Community Health Choice, Inc. also trains staff to be mindful of cultural differences in communication styles, body language, and decision-making processes.

If you need these services, contact our Member Services Department at 1.855.315.5386 or TDD/TTY 711.

If you believS

Arabic العربية ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.855.315.5386.
Chinese 1.855.315.5386