CHORUS COMMUNITY HEALTH PLANS

Enrollment Application for Individual or Family Health Coverage

- All applicants must be U.S. citizens, U.S. nationals, or have eligible immigration status.
- For help with your application, please call our Sales Department directly at 1-844-708-3837 from 8:00 a.m. to 4:30 p.m., Monday through Friday.
  - For interpreter services, call 1-844-201-4672.
  - Hearing-impaired applicants, call 7-1-1.

Once your application is complete, please return it by one of the following options:

- Email: CCHP-MemberSales@chw.org
- Fax: 1-414-266-1611
- Mail: CCHP
  P.O. Box 1997, MS6280
  Milwaukee, WI 53201-1997

Step 1 - Type of Enrollment

☐ **Initial Enrollment** **Date:** _____ **List qualifying events:** _____

☐ **Special Enrollment** **Date:** _____ _____

(Please attach your special enrollment/qualifying life event documentation to this application)

Step 2 - Plan Selection

Please select the plans you are applying for. ☐ **Medical** ☐ **Dental**

Medical Plan name you have selected: _____

Quoted medical premium payment amount: _____

Dental Plan name you have selected: _____

Dental premium payment amount: _____

Step 3 - Applicant Information

Full name: _____ **SSN:** _____ **DOB:** _____ MM/DD/YYYY

Physical address: _____ **Gender:** _____

City: _____ **State:** _____ **County:** **Zip:** _____

Mailing address (if different than above):

_____

_____ _____ _____

City: _____ **State:** **County:** **Zip:**

Preferred phone number: _____ **Other phone number:** _____

Email address: _____

By providing your email, you are agreeing to receive digital communications from CCHP.

Step 4 - Dependent Information

Please list all dependents who will need health coverage. When applying for more than three dependents please attach a separate sheet. If you are applying for a dependent over the age of 26, who is legally disabled and eligible to be on your plan Please submit proof of disability along with this application for approval.

Full name: ______________________ **Relationship:** ____________ **DOB:** ______________
MM/DD/YYYY

SSN: ______________________ **Gender:** ____________ **Marital Status:** ____________

Physical Address (if different than above)**:** ______________________________

City: ______________________ **State:** ____________ **Zip:** ______________

Full name: ______________________ **Relationship:** ____________ **DOB:** ______________
MM/DD/YYYY

SSN: ______________________ **Gender:** ____________ **Marital Status:** ____________

Physical Address (if different than above)**:** ______________________________

City: ______________________ **State:** ____________ **Zip:** ______________

Full name: ______________________ **Relationship:** ____________ **DOB:** ______________
MM/DD/YYYY

SSN: ______________________ **Gender:** ____________ **Marital Status:** ____________

Physical Address (if different than above)**:** ______________________________

City: ______________________ **State:** ____________ **Zip:** ______________

Full name: ______________________ **Relationship:** ____________ **DOB:** ______________
MM/DD/YYYY

SSN: ______________________ **Gender:** ____________ **Marital Status:** ____________

Physical Address (if different than above)**:** _____

City: _____ **State:** _____ **Zip:** _____

Step 5 - Eligibility

Please provide additional health information.

1. **Have you or your spouse (if applying), within the last six months used tobacco FOUR or more times per week on average?** *(Excludes e-cigarettes and religious or ceremonial uses of tobacco.)* ☐ **Yes** ☐ **No**

2. **Are all applicants U.S. citizens or U.S. nationals?** ☐ **Yes** ☐ **No**

   If no, do you have eligible immigration status? ☐ **Yes** ☐ **No**

   If yes – List immigration document type and ID number in the section below.

   If no – You are not eligible for this plan

3. **Are any applicants American Indian or Alaskan Native?** ☐ **Yes** ☐ **No**

   If yes – Is the tribe federally recognized? ☐ **Yes** ☐ **No**

   If no – List name and state of tribe: _____

4. **Are any applicants incarcerated?** ☐ **Yes** ☐ **No**

   If yes – Is applicant facing charges?

If you're not a U.S. citizen and have eligible immigration status, please complete the section below:

Applicant's Full Name: _____

Document Type: _____ **Immigration Document ID Number:** _____

Spouse's Full Name: _____

Document Type: _____ **Immigration Document ID Number:** _____

Dependent's Full Name: _____

Document Type: _____ **Immigration Document ID Number:** _____

Dependent's Full Name: _____

Document Type: _____ **Immigration Document ID Number:** _____

Dependent's Full Name: _____

Document Type: _____ **Immigration Document ID Number:** _____

Step 6 - Other Insurance

Will you or any other proposed dependent have any other insurance coverage, including employer, Medicaid, Medicare, or Dental, when this contract becomes effective? ☐ **Yes** ☐ **No**

If YES, please complete the section below.

List all covered persons names: _____

Insurance Company Name: _____ **Type of Coverage:** _____

Effective Date: _____ **Termination Date:** _____

Is proposed coverage replacing this coverage? ☐ **Yes** ☐ **No**

List all covered persons names: _____

Insurance Company Name: _____ **Type of Coverage:** _____

Effective Date: _____ **Termination Date:** _____

Is proposed coverage replacing this coverage? ☐ **Yes** ☐ **No**

List all covered persons names: _____

Insurance Company Name: _____ **Type of Coverage:** _____

Effective Date: _____ **Termination Date:** _____

Is proposed coverage replacing this coverage? Yes ☐ ☐ **No**

Step 7 - Effective Date Selection

Your effective date will be the first (1st) of the next month if application is received by the fifteenth (15th) day of the prior month. Alternatively, if you apply for coverage after the 15th of the month, your effective date will be the 1st of the following month.

☐ Next available

☐ Requested: _(month) within 60_ days of your signature date for this application.

There are exceptions on effective dates for members enrolling due to a qualifying event such as loss of coverage or the birth of a child. Please contact CCHP to determine your effective date.

Step 8 - Agent / Agency Information

Agent name: _____ **Agent ID (NPN):** _____

Agency name: _____ **Agency phone:**

Agent email: _____ _____

Step 9 - Medical Notice

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue a contract, Chorus Community Health Plans needs to obtain information about the applicant (you) and any dependents from other sources. That information and any subsequent information collected by Chorus Community Health Plans may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding.

If you wish to have a more detailed explanation of our information practices, please contact:
Chorus Community Health Plans
P.O. Box 1997, MS6280
Milwaukee, WI 53201-1997

FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to an applicant or covered person for the purpose of defrauding or attempting to defraud the applicant or covered person with regard to a settlement or award payable from insurance proceeds, shall be reported to the appropriate regulatory agency in your state.

PRIVACY

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law. We collect nonpublic information about you from the following sources: (1) information Chorus Community Health Plans receives from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or Chorus Community Health Plans. We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your nonpublic personal information. We may disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law. CCHP does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

Step 10 - Read and Sign

Your premium payment – I understand CCHP is prepaid health coverage. This means that I pay my premium payment in the month for that month of coverage. I understand if I do not choose an automatic payment option, I will get an invoice in the mail each month.

10-day contract review period – I understand applicants enrolled for coverage shall be provided a 10-day period from receipt of the contract to examine and return the contract and have the premium refunded. If medical services were received during the 10-day period, and I return the contract to receive a refund of the premium paid, I must pay for such services.

Your contract documents – I understand covered benefits, services, utilization management procedures, exclusions, and are subject to the provisions of the contract and/or Evidence of Coverage. These documents may be found on our website at chorushealthplans.org, or you may call the CCHP Sales Department at 844-708-3837, Monday through Friday from 8:00 a.m. to 4:30 p.m. If you or someone you're helping has questions about CCHP, you have the right to get help and information in your language at no extra cost. For interpreter services, call 844-201-4672. Hearing-impaired applicants may call Wisconsin Relay 711.

Dental services are not part of this medical plan – I understand this plan does not include dental services for adults, as well as pediatric dental services as required under the federal Patient Protection and Affordable Care Act. Dental coverage is available in the federal Health Insurance Marketplace and can be purchased as a separate product through CCHP. If you wish to purchase pediatric dental coverage or a separate dental insurance plan you may do so by visiting our website chorushealthplans.org/togdental, contacting your insurance agent, or by visiting healthcare.gov. You may also enroll in coverage by selecting your dental plan choice on this application.

Your protected health information – I hereby authorize to the extent permitted by applicable law, the use or release of my protected health information (PHI) by any person or entity, without limitation including practitioners, providers, and insurance companies to Chorus Community Health Plans or its designees for any permitted purpose. Purposes including, but not limited to evaluating my application for insurance, quality assurance, utilization review, processing of claims, financial audits, or other purposes related to the treatment, payment or healthcare operations activities of Chorus Community Health Plans. This consent shall not permit use or disclosure of PHI when authorization is required by law. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case, it may not be protected under federal privacy rules. Notices of Privacy Practices can be found online at chorushealthplans.org. This authorization shall be valid for two years from this date and you have the right to revoke this authorization at any time by sending written notice to Chorus Community Health Plans.

»» I understand that I am entitled to a copy of this signed application upon request.

»» I acknowledge that I have read and understand this application in its entirety.

Printed Name of Applicant or Legal Guardian

Today's date:

Signature of Applicant or Legal Guardian

Note: Application expires 60 days from the date of your signature.