Individual and Family Plan Enrollment Application – Off Exchange

華人健保計劃 CCHP Health Plan

T: 1-888-681-3888
F: 1-415-955-8819

This form can also be downloaded on CCHP's website: www.cchphealthplan.com/individual-family-plans-enrollment-application

Chinese Community Health Plan (CCHP) will provide translation or other language assistance free of charge in completing the application. The application, together with the Disclosure Form/Evidence of Coverage ("Agreement") constitutes the plan contract, and that applicants may request a copy of the Agreement prior to enrollment to learn the terms and conditions of the plan contract.

Reason for application

Please select one	☐ New Application (during open enrollment period October 15, 2018 – January 15, 2019)
	☐ Special Enrollment (during January 16, 2019 – October 14, 2019, please attach attestation & proof of the qualifying event)
	☐ Adding Spouse/Domestic Partner ☐ Adding Child(ren) Current Member ID#_____ Current Plan: _____

Proposed Effective Date (MM/DD/YY) / /

Please select a plan

Medical Plan Options: ☐ Jade[15] HMO Platinum ☐ Amber[50]HMO Silver ☐ ActiveChoice PPO Silver ☐ Platinum[90] HMO ☐ Gold[80] HMO ☐ Silver[70] Off Exchange HMO ☐ Bronze[60] HMO ☐ Bronze[60] HDHP HMO ☐ Minimum Coverage HMO

Optional Riders: ☐ Adult Vision (VSP) ☐ Adult Dental (Delta Dental)

A. Primary applicant's information

Last Name:	First Name:	MI:	SS#:
Date of Birth (MM/DD/YY) : / /	Age:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married
Email:		Cell Phone:	Home Phone:
Home Address (No P.O. Box)		City:	State: Zip:

We will send all correspondence to your home address. If you have concerns about receiving confidential and private medical information at your home address, designate an address below where you want to receive such notices. You may be able to have medical information sent to you in an alternate format. Please contact CCHP for more information.

Mailing address if different from above:		City:	State: Zip:
Primary Care Physician (PCP) :		Medical Group:	Are you a current patient of this PCP? ☐ Yes ☐ No
Name of Employer:			Work Phone:
Work Address:		City:	State: Zip:

Preferred Written Language: ☐ Chinese ☐ English ☐ Spanish ☐ Other ____

Optional Questions

Your ethnic origin

☐ Asian Indian ☐ Black or African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro
☐ Hmong ☐ Hispanic, Latino or Spanish Origin ☐ Japanese ☐ Korean ☐ Laotian ☐ Native Hawaiian
☐ Samoan ☐ White ☐ Vietnamese ☐ Other ____

B. List all family member(s) to be covered

☐ Spouse ☐ Domestic Partner	Last Name:	First Name:	M.I. :
Date of Birth (MM/DD/YY) : / /		SSN:	Gender: ☐ Male ☐ Female
Primary Care Physician (PCP) :		Medical Group:	Existing Patient? ☐ Yes ☐ No
Dependent # 1	Last Name	First Name	M.I. :
Date of Birth (MM/DD/YY) : / /		SSN:	Gender: ☐ Male ☐ Female
Primary Care Physician (PCP) :		Medical Group:	Existing Patient? ☐ Yes ☐ No
Dependent # 2	Last Name:	First Name:	M.I. :
Date of Birth (MM/DD/YY) : / /		SSN:	Gender: ☐ Male ☐ Female
Primary Care Physician (PCP) :		Medical Group:	Existing Patient? ☐ Yes ☐ No
Dependent # 3	Last Name:	First Name:	M.I. :
Date of Birth (MM/DD/YY) / /		SSN:	Gender: ☐ Male ☐ Female
Primary Care Physician (PCP) :		Medical Group:	Existing Patient? ☐ Yes ☐ No

C. Fill out this section if applicant is using an insurance Agent or Broker

I understand that the broker of record may receive monetary and/or non-monetary payments from CCHP in connection with the purchase of this coverage. I understand my premiums are the same whether or not I use an agent or broker.

Applicant's Signature X	Broker Name:	Date (MM/DD/YY): / /

D. Insurance agent/broker attestation (AB2569, Cal H&S §1389.8)

To be completed by your agent or broker after completion of this application

Notice to agent: If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand ($10,000) dollars, as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies available under current law.

I,_____, assisted the applicant in submitting this application. I advised the applicant to answer all questions completely and truthfully and that no information requested should be withheld. I explained that withholding information may result in cancellation of coverage in the future.

To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

Agent/Broker Signature X		Agent/Broker Name:	Date (MM/DD/YY) : / /
Phone:	Fax:	Email:	CA License Number:
Agent/Broker Company Name:			Note(s) (CCHP Use Only):
Agent/Broker Address:			

E. Conditions of application – Please carefully read the following:

I. General Conditions

Chinese Community Health Plan (CCHP) reserves the right to reject any application for enrollment.

1. I understand that I have no coverage under this application until notified by CCHP that I am accepted.
2. If I am accepted, this application will become part of the agreement between CCHP and myself. Enrolled family members and I agree to be bound by the arbitration clause in the CCHP contract instead of trial by a court or jury.
3. I understand that willful misrepresentation can result in rescission of my coverage. CCHP can only rescind for a material misrepresentation or omission if the misrepresentation or omission is willful.

II. Acknowledgment and Agreement:

I hereby subscribe for myself and any enrolled dependents to the health plan designated here and agree to abide by all terms, conditions and provision of this Individual Membership Contract. I have read and understand the terms on this application and my signature below indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct. I agree to notify CCHP promptly of any facts or circumstances which arise before the effective date of coverage under CCHP which make any of the statements supplied herein incorrect. I understand that coverage may be cancelled if CCHP demonstrates I have been fraudulent or intentionally misrepresented material fact in my application.

III. Disclosure of Personal and Health Information

CCHP understand the importance of keeping your and your dependents' personal and health information private. CCHP protects this information in electronic, written, and oral forms when used throughout our company. CCHP will not disclose this information without your authorization except as permitted by law.

For the purpose of administering your CCHP coverage, CCHP is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, CCHP is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.

A complete explanation of CCHP policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing CCHP's website.

IV. Arbitration Agreement:

I understand that (except for Small Claims cases) any and all disputes, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), which may arise under the agreement between me and my dependents enrolled in the plan and CCHP and any of its affiliates shall be determined by submission to binding arbitration as provided by California law. Any such dispute will not be resolved by a lawsuit or resort to court process except as applicable law provides for judicial review of arbitration proceedings. ALL PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION. For more information regarding binding arbitration, please refer to your Evidence of Coverage.

Applicant Signature X	Print Your Name:	Date (MM/DD/YY): / /
Spouse or Domestic Partner Signature X	Print Your Name:	Date (MM/DD/YY): / /
Signature Required for Dependents Age 18 or over		
Dependent #1 Signature X	Print Your Name:	Date (MM/DD/YY): / /
Dependent #2 Signature X	Print Your Name:	Date (MM/DD/YY): / /
Dependent #3 Signature X	Print Your Name:	Date (MM/DD/YY): / /

Marketing Source

☐ TV ☐ DM ☐ Email Ad ☐ Mobile Ad ☐ Radio ☐ Sing Tao Newspaper ☐ Journal Newspaper ☐ Other Newspaper

☐ Referrals ☐ Street Fair/Event ☐ Other _____

CCHP Use Only

Sales [ ] Manager [ ] Payment Type [CC / Bill / Check#] Amount [ ] Date [ ]

Rec'd by Enrollment [ ] Packet Sent Date [ ]

Special Enrollment Attestation Form

Typically, you may enroll in an individual health plan only during the open enrollment period from Nov 1st to Jan 31st of each year. There are exceptions that may allow you to enroll outside of this period. Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for Special Enrollment Period privileges. If you later determine that this information is incorrect, you may be disenrolled.

Name of Applicant:	Effective Date Requested (DD/MM/YY): / /

Completing this form does not guarantee acceptance of the exception request, please provide the required documentation.

I am certifying I qualify for Special Enrollment due to (check box the reason that best applies):

- ☐ Got married or entered into domestic partnership
- ☐ Divorce, legal separation, dissolution of domestic partnership, or death
- ☐ A child is born, adopted or received into foster care
- ☐ Dependent turns 26 years old
- ☐ Attainment of citizenship
- ☐ Loss of Medi-Cal
- ☐ Loss of Group Coverage (e.g. death of an employee, termination of employment, deduction of hours)
- ☐ Loss of CORBA
- ☐ Loss of Student Health Insurance
- ☐ Ineligible for tax credits or cost-sharing reductions under Covered California
- ☐ Permanently moved into CCHP Service Area
- ☐ Misconduct or misinformation occurred during your enrollment
- ☐ Released from jail or prison
- ☐ Returned from active duty military service
- ☐ Received a certificate of exemption for hardship exception from Health & Human Services
- ☐ Court ordered provision of health insurance
- ☐ Federally Recognized American Indian/Alaska Native
- ☐ Other (Please provide an explanation): _____

Required Documentation for Special Enrollment Periods

A person enrolling as the result of a qualifying life event should provide the proof that the triggering event occurred and the date the event occurred. Most special enrollment periods last 60 days from the date of the qualifying life event.

Event	Supporting Documentation
Marriage	*Marriage certificate*
Divorce	*Divorce decree document*
Birth/Adoption/Legal Guardianship of Child	*Birth certificate or hospital discharge paperwork*
Dependent Child reaches age 26	*Proof of previous health insurance*
Death of policyholder	*Death certificate*
Eligible Immigration Status or US Citizenship	*Valid US passport, Green Card, or legal supporting documentation*
Loss of Employer Coverage	*Proof of previous group health insurance*
Loss of Coverage Through Spouse's Employer	*Proof of previous group health insurance*
Loss of COBRA	*Loss of COBRA letter*
Loss of Medi-Cal	*Loss of Medi-Cal document*
Ineligible for cost-sharing reductions under Covered CA	*Covered CA letter*
Relocation / Move into CCHP Service Area	*Proof of old and new address, such as utility bill, credit card statement, insurance statement, bank statement, driver's license or education institution document. Both document must indicate permanent move occurred within 60 days of application.*

Applicant Signature X	Date (MM/DD/YY) / /