Minnesota Comprehensive Health Association

Instructions & Application for Individual Coverage

www.mchamn.com

MCHA Customer Service
1-866-894-8053
TTY: 952-992-3190 or toll-free at 1-800-841-6753
Monday – Friday: 7 a.m. – 6 p.m. CST

MCHA Broker / Agent Service Center
952-992-2200 or toll-free at 1-800-936-6880
Monday – Friday: 8 a.m. – 5 p.m. CST

Please mail the completed application and applicable premium to:

Minnesota Comprehensive Health Association/Medica
Mail Route CP382
401 Carlson Parkway
Minnetonka, MN 55305-5387

Failure to completely answer all questions and to submit required documentation may delay the processing of your application or the date your coverage becomes effective. Your payment must accompany this application.

Instructions for Application

This application contains Sections A-N. **<u>You must complete all sections identified on the application as "Required Information."</u>** Incomplete applications will be returned to you for completion and may delay your effective date of coverage. Some areas of the application require you to initial the section, providing proof you have read the information and have provided accurate information**.**

If you have questions about MCHA, eligibility, health plan options and services available to you, call the MCHA Customer Service telephone number listed on the front cover of this application or refer to the "MCHA Summary of Benefits of the Individual Deductible Plan Options and a Federally Qualified High Deductible Health Plan" brochure.

The following information corresponds with each section on the application.

Section A. Plan Option Requested (*Required Information)*
There are six plan options available. Choose the plan in which you want to enroll.

- $500 Individual Deductible Plan – Deductible is split between $400 for medical benefits and $100 for prescription drug benefits.
- $1,000 Individual Deductible Plan – Deductible is split between $800 for medical benefits and $200 for prescription drug benefits.
- $2,000 Individual Deductible Plan – Deductible is split between $1,600 for medical benefits and $400 for prescription drug benefits.

Each of the three above plans has a $3,000 annual out-of-pocket maximum.

- Federally qualified High Deductible Health Plan (HDHP) - The combined annual deductible and out-of-pocket maximum (for both medical and drugs benefits) is $3,000 for an individual, and $6,000 for a family. You are responsible for the establishment and coordination of any associated Health Savings Account (HSA) services.
- $5,000 Individual Deductible Plan – Deductible is split between $4,000 for medical benefits and $1,000 for prescription drug benefits. $5,000 annual out-of-pocket maximum.
- $10,000 Individual Deductible Plan – Deductible is split between $8,000 for medical benefits and $2,000 for prescription drug benefits. $10,000 out-of-pocket maximum.

Section B. Applicant and Dependent Information *(Required Information)*
The applicant is the individual applying for MCHA coverage. *Dependent Information* (#15) is required only if you (the applicant) add dependent(s) to your policy at the time of application. Eligible dependents may be added to your policy at the time of application, including: a spouse, unmarried natural or adopted children, a child placed for adoption, a child under legal guardianship, a stepchild, and an unmarried grandchild who resides with applicant. A dependent child is eligible for coverage up to age 25. A dependent <u>cannot</u> be added to the policy at a later date unless the dependent is a newborn, a newly adopted child, or a new spouse. A new spouse must be added to the plan within 30 days from the date of marriage.

Section C. Residency (*Required Information)*
You and dependents (if applying for coverage) must be residents of the State of Minnesota. You (the applicant) must provide proof of residency. The length of residency needed to qualify for coverage differs depending on the eligibility category under which you apply:

- If you apply under section "H. Eligibility Categories" option number 1 (Loss of Group Coverage) or option number 2 (Health Coverage Tax Credit program) you must provide proof of Minnesota residency as of the date you are making application to MCHA.
- If you are applying under section "H. Eligibility Categories" option number 3 (Ineligible for the Federal Medicare Program), option number 4 (Health Related Rejection), or option number 5 (Presumptive Condition(s)), you must provide proof of Minnesota residency for at least six (6) months prior to the date you are making application to MCHA.

Required Documentation:
You are required to include proof of Minnesota residency with your application by including a copy of your Minnesota driver's license, utility bill or voter registration documenting your Minnesota address and dated within the last six (6) months. If the applicant is a child under age 19 or under school age, MCHA will accept school records with the child or parent's/legal guardian's name and address, or a divers license, utility bill, voter registration from the parent or legal guardian. Documents must include the name of the applicant or parent/legal guardian of applicant and current Minnesota mailing address, and must be dated within the last six (6) months.

Section D. Tobacco Designation (*Required Information)*
MCHA has "Standard" (non-Tobacco User) premium rates and "Tobacco User" premium rates. You and your dependent spouse (if applying for coverage) must identify if you have used tobacco, including: smoking cigarettes, cigars, pipe, use chewing tobacco, snuff or have used nicotine chewing gum, the nicotine patch or other prescription or over the counter smoking cessation products within the 12 months immediately preceding the date of the application. You must pay the appropriate premium rate that corresponds to your tobacco-user designation.

Section E. Employment Status (*Required Information)*
You are required to identify your employment status. You are **not eligible** for MCHA coverage if you are eligible for an employer's health plan, except for enrollment or continued enrollment necessary to cover conditions that are subject to an unexpired pre-existing condition limitation, or pre-existing condition exclusion or an exclusionary rider under the employer's health care plan, or if you have met an annual maximum benefit under the employer's health plan. Minnesota law prohibits employers from directing an employee to apply for MCHA if they are eligible for the employer's health care plan. Identified cases are reported to the Minnesota Department of Commerce for appropriate action.

Section F. Other Health Coverage Information (*Required Information)*
For purposes of determining eligibility, you are required to provide information on your prior health insurance coverage. For potential coordination of benefits (COB), you are also required to identify other health insurance coverage you have currently.

Section G. Reason for Applying for MCHA *(Required Information)*
Identify the reason(s) you are applying for MCHA coverage. This information is kept confidential and is not used to determine eligibility.

Section H. Eligibility *(Required Information)*
There are five (5) different eligibility categories by which you can apply for MCHA coverage. Review all the eligibility categories **and choose only one (1)**. First, review number "1. Loss of Group Coverage." If applicable, complete this section and include required documentation. Otherwise, choose an eligibility category from numbers 2-5, check the appropriate boxes, and include required documentation.

Eligibility:
1. Loss of Group Coverage: Eligibility under this category is determined by the Health Insurance Portability and Accountability Act (HIPAA), which allows an individual to avoid a pre-existing condition limitation or waiting period. You must satisfy all of the following requirements to be eligible under this category:

- You must have maintained creditable coverage for at least 18 months with no lapse in coverage of more than 63 days.
- Your most recent coverage must be in a group plan through your or a family member's employer sponsored plan, church plan, governmental plan or another state's high risk pool (must be a 501C (26) or the state's HIPAA alternative mechanism).
- If available, you must have elected and exhausted health benefits through COBRA or other similar State or Federal continuation plan.
- Your prior coverage was not lost because you stopped paying the premiums or because you committed fraud.
- You cannot be eligible or have the option to participate in coverage under any other group health plan offered by your or a family member's employer and are not eligible for Medicare or Medicaid.

Documentation supporting eligibility under this category includes a copy of the Certificate of Creditable Coverage, a HIPAA document, or documents that collaborate creditable coverage (including explanations of benefits or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage).

If you are eligible under this category, the effective date of coverage will be the date the application, all required documentation and premium is received by MCHA. A pre-existing limitation condition period does not apply.

2. Health Coverage Tax Credit (HCTC) Program: Eligibility under this category is determined by your and your dependent(s) loss of health coverage, due to a job loss. Job loss must be due to the effects of international trade. You must be Department of Labor certified to receive partial coverage of your health insurance premiums under the IRS Health Coverage Tax Credit. You may receive benefits

through Trade-Adjustment Assistance, Alternative Trade Adjustment Assistance the Pension Benefit Guaranty Corporation. You must have registered for and received notice from the HCTC program that you are eligible for the assistance.
You must include a copy of the HCTC candidate letter.

If you are eligible under this category, the effective date of coverage will be the date the application, all required documentation and premium is received by MCHA. A pre-existing limitation condition period does not apply.

3. Ineligible for the Federal Medicare Program: You are eligible under this category if you have reached age 65 or over and are *not* eligible for the health insurance benefits under the Federal Medicare program. You must submit a letter from Social Security stating you are ineligible for Medicare.

If you are eligible under this category, the effective date of coverage will be the date the application and all required documentation and premium is received by MCHA or a future date as identified by you. A pre-existing limitation condition period does not apply.

4. Health Related Rejection: Eligibility under this category is determined by whether you have a health related condition that prevents you from being accepted for individual insurance coverage with another insurance carrier. You must have received a rejection of coverage due to a health condition(s) within the last six (6) months, from a:
a) Minnesota health insurance carrier; or
b) Minnesota licensed insurance agent (the agent must complete the *"Agent Certification of Eligibility"* information within section "L. Agent Information").

If you are eligible under this category, the effective date of coverage is the date the application and all required documentation and premium is received by MCHA, or if a preexisting condition limitation waiver is requested and approved, the effective date will be backdated to the day following termination of prior coverage. If you choose a date other than the day after termination of prior coverage, the waiver is relinquished and a six-month pre-existing condition limitation will apply to your policy. Refer to section "I. Request for Pre-existing Condition Limitation Waiver." If you are accepted for coverage, MCHA will notify you by mail on the status of your request for a waiver of the pre-existing condition limitation.

5. Presumptive Condition(s): If your health status disqualifies you from coverage in the private market, and you have been treated for one of the following conditions within the last 3 years, you are eligible for MCHA coverage. Your physician must complete the "Physician's Statement" certifying eligibility, and identifying you have one of the following conditions or diagnoses:

AIDS/HIV
Alzheimer's Disease
Amyotrophic Lateral Sclerosis (ALS)
Angina Pectoris
Anorexia Nervosa or Bulimia
Aortic Aneurysm
Ascites
Chemical Dependency
Chronic Pancreatitis
Chronic Renal Failure
Cirrhosis of Liver
Coronary Insufficiency
Coronary Occlusion
Crohn's Disease (Regional Eneritis)
Cystic Fibrosis
Dermatomyositis
Friedreich's Ataxia
Hemophilia
Hepatitis C
History of Major Organ Transplant
Huntington Chorea
Hydrocephalus
Insulin Dependent Diabetes
Leukemia
Malignant Lymphoma
Malignant Tumors
Metastatic Cancer
Motor/Sensory Aphasia
Multiple Sclerosis
Muscular Dystrophy
Myasthenia Gravis
Myocardial Infarction
Myotonia
Open Heart Surgery
Paraplegia
Parkinson's Disease
Polyarteritis Nodosa
Polycystic Kidney
Primary Cardiomyopathy
Progressive Systemic Sclerosis (Scleroderma)
Quadriplegia
Stroke
Syringomylia
Systemic Lupus Erythematosis (SLE)
Wilson's Disease

If you are eligible under this category, the effective date of coverage is the date the application and all required documentation and premium is received by MCHA, or if a preexisting condition limitation waiver is requested and approved, the effective date will be backdated to the day following termination of prior coverage. If you choose a date other than the day after termination of prior coverage, the waiver is relinquished and a six-month pre-existing condition limitation will apply to your policy. Refer to section "I. Request for Pre-existing Condition Limitation Waiver." If you are accepted for coverage, MCHA will notify you by mail on the status of your request for a waiver of the pre-existing condition limitation.

Section I. Request for Pre-existing Condition Limitation Waiver *[Required information only if you are applying for eligibility, under section "H. Eligibility" option number 4 (Health Related Rejection) or option number 5 (Presumptive Condition(s), and requesting a waiver.]*
If applying for coverage under one of the above two categories, you and your dependent(s) (if added to the policy) are subject to a Pre-existing Condition Limitation. This means that your MCHA policy will not provide benefits for expenses incurred during the first six (6) months of coverage for treatment of an injury, illness, or other physical or mental condition (including treatment with prescription drugs, provision of prenatal care and maternity related services) if that injury, illness, or condition was diagnosed, treated, or evaluated during the 90-day period immediately prior to the effective date. This rule does not apply to newborns or children placed for adoption who are added to your policy as new dependents after the original effective date of coverage.

Under certain situations you may be eligible for a waiver of the pre-existing condition limitation. This section allows you to apply for a waiver. To be eligible for a waiver you must apply for MCHA coverage within 90 days of termination of your prior coverage and provide the required documentation for review. Application for a waiver does not guarantee the waiver of the pre-existing condition limitation. If you are accepted for coverage, MCHA will notify you by mail on the status of your request for a waiver of the pre-existing condition limitation.

If you are approved for a waiver of the pre-existing condition limitation, your effective date of coverage will be retroactive to the day after the cancellation date of your previous health coverage. If your pre-existing condition limitation waiver is approved, and you choose to have a different effective date other than the day after the cancellation date of your previous health coverage, you relinquish the waiver of the pre-existing condition limitation (meaning a six-month pre-existing condition limitation will apply to your policy).

Section J. Applicant's Disclosure Authorization and Declaration *(Required Information)*
You must initial each area of this section, verifying you have read and understand the information. You must sign and date the **bold** statement confirming you have read and understand all disclosure statements listed.

"Alternative Effective Date": You may request a *future* effective date for your MCHA coverage if you choose a date other than the day the completed application is received by MCHA. Indicate in this section the future date you wish coverage to go into effect. Retroactive effective dates cannot be considered unless you apply for and receive approval for a waiver of the pre-existing condition limitation section "I. Request for Pre-existing Condition Limitation Waiver." If you are eligible for a waiver, you cannot choose an alternative effective date and maintain the waiver.

Section K. Premium Billing *(Required Information)*
You must indicate how you want to pay your premiums. You have two options:

- Monthly payments: For monthly payments, you are required to utilize the Automatic Clearing House (ACH) process. This is an automatic payment process that will deduct the premium payment from your designated checking or savings account. This withdrawal usually occurs about the 5th day of each month.
- Quarterly payments: Quarterly payments are for each calendar quarter (January-March, April-June, July-September, and October-December) and can be made through the ACH deduction process or by receiving a premium statement and mailing in your payment. Premium payments are due the first day of each calendar quarter (January 1st, April 1st, July 1st and October 1st).

You will receive your MCHA premium notice around the 20th day of the month prior to the payment due date.

Whether you choose the monthly or quarterly premium billing option, remember to **include your first premium payment with this application** [coinciding with your choice of monthly (1 month)

or quarterly (3 months) payments]. Failure to include the proper premium payment will delay the processing of your application and potentially the effective date of coverage.

Each MCHA policyholder is responsible to make premium payments on behalf of themselves and any dependent(s) covered under the policy. MCHA **does not** accept premium payments from an employer or third party administrator.

Section L. Agent Information *[Required information to be completed by a Minnesota licensed health insurance agent if you have chosen to apply for coverage with agent assistance or if you are applying under section "H. Eligibility" option number 4 (Health Related Rejection) and the agent is certifying that you are not eligible for individual health insurance coverage with another health insurance carrier.]*

If you choose to have assistance from a Minnesota licensed health insurance agent in completing and submitting your MCHA application, the agent will received a one (1) time $50 referral fee from MCHA upon acceptance of the application and receipt of the first MCHA premium payment.

Agent Certification of Health Related Rejection:
If an agent is certifying your eligibility under section "H. Eligibility" option number 4 (Health related Rejection) the agent must fully complete, sign and date this section.

Section M. Check List
Review the checklist to help assure all necessary information and documentation is included with your application. Incomplete applications and missing documentation will delay the processing of your application and may possibly affect your effective date of coverage.

IMPORTANT INFORMATION:

Mail the completed application, required documentation and applicable premium to:

Minnesota Comprehensive Health Association
Medica
Mail Route CP382
401 Carlson Parkway
Minnetonka, MN 55305-5387

✓ Your first monthly or quarterly premium payment [coinciding with your choice of monthly premium (one month) or quarterly premium (three months) designation] must accompany this application. Refer to the "MCHA Standard/Tobacco-User Premium Rates" sheet to determine the appropriate premium due.

✓ Failure to completely answer all required information, and failure to submit all required documentation may delay the processing of your application and the effective date of coverage.

✓ MCHA has 30 days to process your application from the date the completed application, with the required documentation, is received.

Minnesota Comprehensive Health Association

Application for Individual Coverage

Upon completion remove instruction pages at perforations.

Please mail the completed application, all necessary documentation and applicable premium to:

Minnesota Comprehensive Health Association/Medica
Mail Route CP382
401 Carlson Parkway
Minnetonka, MN 55305-5387

Failure to completely answer all questions and to submit required documentation may delay the processing of your application or the date your coverage becomes effective. Your payment must accompany this application.

For Internal Use Only

Effective Date:	Group Acct. #:	Receipt Date:	Processed by:
Check Number(s):		Amount of Premium Rec'd:	

COM1532-11007

A. Plan Option: *Required Information*

Choose the plan in which you want to enroll:

☐ $500 individual deductible plan	☐ High Deductible Health Plan (HDHP) $3,000 individual/$6,000 family deductible
☐ $1,000 individual deductible plan	☐ $5,000 individual deductible plan
☐ $2,000 individual deductible plan	☐ $10,000 individual deductible plan

B. Applicant and Dependent Information (please print): *Required Information*

1. Last Name of Applicant	2. First Name	3. MI	4. Social Security Number

5. If applicant is a minor child, please list parent(s) or legal guardian(s)

6. Age	7. Birth Date (mm/dd/yy)	8. Gender	9. Marital Status
		☐ Female ☐ Male	☐ Single ☐ Married ☐ Divorced ☐ Widowed

10. Home Telephone	11. Work Telephone	12. E-mail

13. Residence Address (**required**): Number and Street City State Zip

14. Optional Address Information (**only if different from residence address above**)

Billing Address

In Care of: Number and Street City State Zip

Claims/EOB Correspondence Address

In Care of: Number and Street City State Zip

15. Dependent Information (list dependent(s) only if you add them to your policy of coverage.) Attach an additional sheet if needed.

	First and Last Name	Male/Female (M) (F)	Birth date	Social Security Number
Spouse				
Child				
Child				
Grandchild				

C. Residency: *Required Information*

All applicants are required to provide proof of Minnesota residency. Attach one acceptable form providing proof of residency. Acceptable forms of documentation include: a copy of your driver's license, utility bill or voter registration that includes your Minnesota address. If applicant is a child under age 19 or under school age, school records with the child or parent's/legal guardian's name and address, or a driver's license, utility bill, voter registration from the parent or legal guardian are acceptable.

- Documents proving residency must include the name of the applicant or parent/legal guardian of applicant and current Minnesota mailing address.
- Proof of residency must be current or dated within the period 6 months prior to your application.

Complete the following information:

1. I am a resident of Minnesota. My principal and permanent home is in Minnesota. ☐ Yes ☐ No
2. I have been a Minnesota resident for: ____Years ____Months

INITIALS:_____

3. My dependent(s) (if listed above) are residents of Minnesota. ☐ Yes ☐ No If "No" list the name(s) and their state of residency.

_____

D. Tobacco Designation: *Required Information*

Have you or your dependent(s) (if listed above) smoked cigarettes, cigars, a pipe, used chewing tobacco, snuff or nicotine chewing gum, the nicotine patch or other prescription or over the counter smoking cessation products in the 12 months immediately preceding the date of this application? ☐ Yes ☐ No

If you answered "Yes" to the above question, list the names of those individuals to whom this applies:

_____ **INITIALS:_____**

E. Employment Status: *Required Information*

Complete the following section:

1. Are you a dependent of an employed person? ☐ Yes ☐ No
2. What is your employment status or the employed person who is responsible for the dependent:

Employed full-time: ☐ Yes ☐ No Employed part-time: ☐ Yes ☐ No Self-employed: ☐ Yes ☐ No Unemployed: ☐ Yes ☐ No

3. What is the occupation of employed person: _____

a. Identify the name, address, and phone number of your employer or the employed person responsible for the dependent:

Name: _____ Telephone number: _____

Address: _____

b. Does the employer currently employ 51 or more employees? ☐ Yes ☐ No

c. Does the employer offer health coverage to its employees? ☐ Yes ☐ No

d. Does the employer offer health coverage to the dependents of the employees? ☐ Yes ☐ No

e. If health coverage is offered, is coverage available through a group policy or an individual plan? ☐ Group ☐ Individual

f. Are you covered under the employer's health plan? ☐ Yes ☐ No If "No", please explain why you are not currently covered by health coverage offered through the employer:

_____

g. Is the dependent covered under the employer's health plan? ☐ Yes ☐ No If "No", please explain why the dependent(s) are not currently covered by health coverage offered through the employer:

h. If you are covered under the employer's health plan, do you have a pre-existing condition limitation period on your policy?

☐ Yes ☐ No If "Yes," identify when the pre-existing condition limitation will expire: _____

i. If you are covered under the employer's health plan, do you have a dollar or benefit limitation that has been exceeded?

☐ Yes ☐ No If "Yes," identify the dollar limit or benefit limitation that has been exceeded and provide documentation from the current health carrier or the employer verifying this information: Dollar limitation (annual or lifetime limit): _____

Benefit limitation (identify the benefit and the limitation):_____

Minnesota law prohibits employers from encouraging or directing an employee or applicant to apply for MCHA coverage if they are eligible for the employer group plan coverage. Identified cases are reported to the Minnesota Department of Commerce for appropriate action.

F. Other Health Coverage Information: *Required Information*

Are you or any dependent(s) listed in section "B. Applicant and Dependent Information" covered by:

1. Medical Assistance? ☐ Yes ☐ No If "Yes", identify who is covered: _____

2. General Assistance? ☐ Yes ☐ No If "Yes", identify who is covered: _____

3. Minnesota Care? ☐ Yes ☐ No If "Yes", identify who is covered: _____

4. Medicare? ☐ Yes ☐ No If "Yes", identify who is covered and complete a.-d. below:

a. Effective date of Hospital Insurance (Medicare Part A)_____

b. Effective date of Medical Insurance (Medicare Part B)_____

c. Effective date of Pharmacy Insurance (Medicare Part D)_____

d. Your Medicare number_____

5. Any other current health coverage? ☐ Yes ☐ No If "Yes," who is covered? _____

If "Yes," identify the type of policy: ___ Employer group policy ____ Individual plan policy

6. Identify your current or previous health insurance carrier: ☐ Current health carrier ☐ Previous health carrier

a. Name of health insurance carrier:	b. Dates of coverage: From: To:
c. Name of policyholder:	d. Phone number of health insurance carrier:
e. Identification number of coverage:	f. Group number (if any):
g. Name of employer providing coverage:	h. Phone number of employer providing coverage:

G. Reason for Applying for MCHA: *Required Information*

1. I am unable to obtain individual coverage because of a health related condition. ☐ Yes ☐ No

If "Yes" check the box identifying the health condition that prevents you from obtaining coverage. (*This information is confidential and is not be used to determine eligibility.*

☐ AIDS/HIV	☐ Confidential per previous insurer	☐ Kidney disorder
☐ Allergies	☐ Endocrine disorder	☐ Joint disorder
☐ Arthritis/osteoporosis	☐ Eye/ear condition	☐ Liver disorder
☐ Asthma	☐ Gastrointestinal condition	☐ Mental health condition
☐ Back/neck condition	☐ Gynecological/genitourinary	☐ Muscular condition
☐ Blood disorder	☐ Headaches	☐ Neurological disorder
☐ Breast disease	☐ Height/weight condition	☐ Pregnancy
☐ Cancer	☐ High cholesterol	☐ Respiratory disorder
☐ Cardiovascular condition	☐ High cost of medications	☐ Skin disorder
☐ Chemical dependency	☐ Hypertension	☐ Other (please identify condition):_____

If your dependent(s) are applying for coverage, have they been unable to obtain individual coverage because of a health related condition? ☐ Not applicable ☐ No ☐ Yes If "Yes", check the box and *list the dependents name* after the primary health condition that prevents them from obtaining coverage.

☐ AIDS/HIV	☐ Confidential per previous insurer	☐ Kidney disorder
☐ Allergies	☐ Endocrine disorder	☐ Joint disorder
☐ Arthritis/osteoporosis	☐ Eye/ear condition	☐ Liver disorder
☐ Asthma	☐ Gastrointestinal condition	☐ Mental health condition
☐ Back/neck condition	☐ Gynecological/genitourinary	☐ Muscular condition
☐ Blood disorder	☐ Headaches	☐ Neurological disorder
☐ Breast disease	☐ Height/weight condition	☐ Pregnancy
☐ Cancer	☐ High cholesterol	☐ Respiratory disorder
☐ Cardiovascular condition	☐ High cost of medications	☐ Skin disorder
☐ Chemical dependency	☐ Hypertension	☐ Other (please identify condition):_____

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2. Check the one (1) reason that best describes why you are applying for MCHA coverage:

☐ MCHA premium rates were less than premium rates quoted to me for a comparable policy in the private market.
☐ I was unable to afford or to continue to afford my premium rates for COBRA or other continuation coverage.
☐ I have exhausted my lifetime benefits under my current employer policy. Employer name:_____
☐ I have exhausted my annual benefits under my current employer policy. Employer name: _____
☐ My employer sponsored retiree plan was cancelled, benefits reduced or premiums became unaffordable.
Employer name: _____
☐ I was unable to continue my health coverage because no continuation was available through my employer.
Employer name: _____
☐ My employer went bankrupt or went out of business. Employer name: _____
☐ My employer laid off me off without the option for continued coverage. Employer name: _____
☐ My employer cancelled its group coverage. Employer name: _____
☐ My insurance company cancelled my individual policy or my employer's group policy.
☐ I am employed and eligible for group coverage however, I have a pre-existing condition limitation on my policy.
Employer name: _____

If you were previously employed, is the employer's group health policy: _____ Self-Insured ____ Fully-Insured

(A self-insured employer funds claim payments, and a fully insured employer pays premiums to an insurance company who funds the claim payments).

H. Eligibility: *Required Information*

Review the eligibility options below and choose ONLY one (1). First, review number "1. Loss of Group Coverage" - all statements must be applicable, checked, and you must include the required documentation. Otherwise, choose an eligibility category from numbers 2-5 below, check the appropriate boxes and include the required documentation.

1. Loss of Group Coverage – Health Insurance Portability and Accountability Act [HIPAA]:

All statements below MUST apply and be checked. You MUST include a Certificate of Creditable coverage showing 18 months of continuous coverage from your previous carrier(s). *(Refer to the Instructions for other documentation options.)*

- ☐ a) I have elected and exhausted health benefits through COBRA or a similar State or Federal continuation plan, if the option was available.
- ☐ b) I have had 18 months of continuous coverage (uninterrupted qualifying coverage) under a health plan, with my most recent coverage being an employer sponsored, church, or government plan (state risk pools plans must be 501c (26) or state's HIPAA alternative mechanism).
- ☐ c) I have had no more than a 63-day break in coverage.
- ☐ d) I have not been subject to termination of COBRA coverage because I failed to pay my premium or because I committed acts of fraud.
- ☐ e) I am not eligible for Medicare or Medicaid.
- ☐ f) I do not have the option of other health insurance coverage (as a dependent or otherwise).

No pre-existing condition limitation applies to this eligibility category. The effective date of coverage is the date MCHA receives all necessary information to process the application.

2. Health Coverage Tax Credit (HCTC) program

Check the statement that correctly applies to you. You MUST include a copy of the HCTC candidate letter.

- ☐ a) I am a retiree aged 55 to 64 receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC); or
- ☐ b) I am eligible for Trade Adjustment Assistance (TAA) or Alternative Trade Adjustment Assistance (ATAA).

No pre-existing condition limitation applies to this eligibility category. The effective date of coverage is the date MCHA receives all necessary information to process the application.

3. Ineligible for the Federal Medicare program

You MUST include written documentation from Social Security stating that you are not Medicare eligible.

- ☐ I have reached age 65 or over and I am not eligible for the health insurance benefits under the Federal Medicare program.

No pre-existing condition limitation applies to this eligibility category. The effective date of coverage is the date MCHA receives all necessary information to process the application.

4. Health Related Rejection

Check the statement that applies.

- ☐ a) I have received, within the last six (6) months, a rejection or notice of benefit reduction from a health insurance carrier for individual health insurance coverage due to health related reasons. **You MUST include a dated copy of the denial letter you received including the name of the health insurance company that issued the denial.**
- ☐ b) I have received a rejection of individual health insurance coverage due to a health related reason(s) from a Minnesota licensed insurance agent. **A Minnesota licensed insurance agent MUST complete section "L. Agent Information - Agent Certification of Health Related Rejection" of this application.**

A six (6) month pre-existing condition limitation applies to this eligibility category. To request a waiver of the pre-existing condition limitation, refer to section "I. Request for Pre-existing Condition Limitation Waiver" on the next page. The effective date of coverage is the date MCHA receives all necessary information to process the application, unless a waiver is granted or a future effective date is requested (refer to instructions).

5. Presumptive Condition(s)

Your physician MUST complete the "Physician's Statement" below, to certify that you have a presumptive condition listed in the instructions.

☐ I have a medical condition(s) that qualifies me for MCHA coverage.

Physician's Statement

Identify condition and last date(s) of treatment: Applicant MUST have been treated within the last 3 years. *(Refer to the Instructions for the list of MCHA presumptive conditions.)*

Physician's Name (please print)	Physician's License Number	Physician's Signature	Date

A six (6) month pre-existing condition limitation applies to this eligibility category. To request a waiver of the pre-existing condition limitation, refer to section "I. Request for Pre-existing Condition Limitation Waiver" on the next page. The effective date of coverage is the date MCHA receives all necessary information to process the application, unless a waiver is granted or a future effective date is requested (refer to instructions).

I. Request for Pre-existing Condition Limitation Waiver: *Required information when applying for eligibility under number 4 or 5 on the previous page and requesting a waiver.*

- **To be eligible for a waiver of the pre-existing condition limitation, you must apply for MCHA coverage within 90 days of the termination date of your prior coverage.**
- **Check all boxes that apply to your situation and provide required documentation.**
- **Completion of this information does not guarantee a waiver of the pre-existing condition limitation. You will be notified by mail of the status of your waiver request.**

☐ **1. My employer terminated coverage without offering continuation coverage**. Provide documentation from your employer or health insurance carrier identifying the cancellation date and the reason coverage was terminated.

☐ **2. I have exhausted my continuation coverage under COBRA or other continuation coverage under a similar state law.** Provide documentation from your employer or health insurance carrier stating you have exhausted your continuation rights. Identify the effective date and cancellation date of your prior coverage and current paid-to-date of your continuation policy.

☐ 3**. I was unable to afford or continue to afford my premiums for COBRA or other continuation coverage under a similar state law.** Provide documentation from your employer or health insurance carrier identifying the cancellation date and provide documentation of your COBRA/continuation premium rates.

☐ **4. I was terminated or laid off (voluntarily or involuntarily) from employment and I am unable to exercise my option to continue my group coverage.** Provide documentation from your employer identifying the cancellation date and the reason continuation coverage was not available.

☐ 5**. I was covered by an employer retiree plan and the coverage is no longer available.** Provide documentation from your employer identifying the cancellation date and reason coverage was terminated.

☐ 6**. My previous coverage provided by a rehabilitation facility and coverage was terminated.** Provide documentation from rehabilitation facility identifying the cancellation date and reason the coverage was terminated.

☐ 7**. I was covered under a conversion policy and I cancelled the coverage.** Provide documentation from your health insurance carrier identifying the cancellation date of your conversion policy.

☐ **8. My health insurance carrier terminated my *group* health insurance coverage. My coverage was not terminated because I failed to pay premiums, or because I voluntarily terminated coverage, or because I committed fraud.** Provide documentation from your previous health insurance carrier identifying the cancellation date and the reason coverage was terminated.

☐ 9**. My health insurance carrier terminated my *individual* health insurance coverage. My coverage was not terminated because I failed to pay premiums, or because I voluntarily terminated coverage, or because I committed fraud or moved out of the service area.** Provide documentation from your previous health insurance carrier identifying the cancellation date and reason the coverage was terminated.

☐ 10**. My previous coverage ended due to insolvency of the health insurance carrier.** Provide documentation from the health insurance carrier identifying the date your benefits were exhausted.

☐ **11. I have exceeded the lifetime maximum benefit under my previous coverage.** Provide documentation from your health insurance carrier identifying the date your benefits were exhausted.

☐ 12**. I have exceeded the annual maximum benefits under my current coverage.** Provide documentation from your health insurance carrier identifying the date your annual maximum benefits were met.

☐ 13**. I was enrolled in Medical Assistance, General Assistance Medical Care, or MinnesotaCare program and coverage was terminated.** Provide documentation from the applicable program identifying the cancellation date from the program.

If the waiver of pre-existing condition is approved, I understand my effective date of coverage will be to the day after the cancellation date of my previous health coverage. **INITIALS:_____**

If I choose an effective date other than the day after the cancellation date of my previous coverage I understand that I relinquish the waiver of pre-existing condition. **INITIALS:_____**

I have reviewed the above list of waiver exceptions and I am *not* seeking a waiver of the Pre-existing Condition Limitation. I understand that a six (6) month Pre-existing Condition Limitation will be applied to my policy. **INITIALS:_____**

J. Applicant's Disclosure Authorization and Declaration: *Required Information*

I declare that no person named is currently covered by an MCHA policy; that the foregoing statements and answers are complete, accurate, and true and that any coverage issued will be in full reliance upon this representation; and I understand and agree that no coverage shall be effective until all requirements have been completed, received and approved by MCHA. I further acknowledge that any inaccurate, false, or fraudulent statements may lead to rescission of coverage issued.

INITIALS:_____

I understand and agree that referring agents are not authorized to interpret, amend, or alter the terms of the MCHA insurance policy, nor are referring agents authorized to bind MCHA in any way.

INITIALS:_____

I understand that MCHA has 30 days to process this enrollment form. Coverage shall be effective the date MCHA receives all materials necessary to constitute a completed enrollment form, unless otherwise noted and initialed in section "I. Request for Pre-existing Condition Limitation Waiver" or in section "J. Applicant's Disclosure Authorization and Declaration –Alternative Effective Date."

INITIALS:_____

I herby authorize and request any hospital, clinic, institution, physician, or other person to furnish MCHA or its writing carrier full details of diagnosis, treatment, medical history, and any other information and conclusions about me and any member of my family, and to accept as valid a photocopy of this authorization and my signature. I understand that MCHA keeps this information confidential, but may release it if I authorize release, or under circumstances where state or federal law permits or requires release without authorization, including release to an entity with which MCHA or its writing carrier has contracted for disease management services. For purposes of obtaining information in connection with this application, reinstatement, or change in policy benefits, this release is valid for as long as I remain continuously insured by MCHA. I understand that I am entitled to receive a copy of this release. I understand that I may revoke this authorization by providing written notice to MCHA or its writing carrier. I understand that if I revoke this authorization, this may affect enrollment for me or my dependents.

INITIALS:_____

I authorize any insurance company, institution, employer, or person that has my records or knowledge of my health history or that of any of my family members for whom insurance is requested to give such information to MCHA or its writing carrier. I understand that a reproduction of this authorization shall be as valid as the original. I understand that information obtained will remain subject to the protections of Health Insurance Portability and Accountability Act's privacy standards.

INITIALS:_____

The information I provide on this form and any attachment is private data under Minnesota law. By providing this data, I authorize MCHA and its writing carrier to use and disclose the data as follows: The purpose and intended use of the data I provide to determine my eligibility for the state plan. The law does not require me to provide any data, but my failure to do so will result in my loss of eligibility for the state plan. Any data I provide may be made available to the employees, agents, directors, or officers of MCHA or its writing carrier. It may also be made available to provide peer review panels or consultants, contributing members of MCHA, nurse line or disease management entities, the Minnesota Commerce Department, actuarial or research organizations, or other persons authorized by law to receive such data. Unless revoked, this authorization remains in effect as long as I remain continuously insured by MCHA.

INITIALS:_____

I have read the above statements; I agree to supply the data on this form with full knowledge of the information provided in these statements.

X_____	_____	X_____	_____
Signature of Applicant	Date	Signature of Parent (if applicant is under age 18)	Date

Alternate Effective Date

I choose an effective date other than the day the completed application and necessary documentation was received. ☐ Yes ☐ No

- If "Yes", specify the requested future effective date: _____
- If you have applied under the Health Insurance Portability Accountability Act (HIPAA), refer to "Section H. Eligibility" option "1", the future effective date can not exceed 63 days from the date of termination of prior coverage.

INITIALS:_____

K. Premium Billing Options: *Required Information*

Will you have assistance from an organization or employer to pay MCHA premiums? ☐ Yes ☐ No If "Yes", identify the organization or employer that will assist you:

☐ Department of Human Services (DHS) ☐ American Kidney Fund ☐ Other_____

☐ Employer/Address/Phone # _____

Choose one billing option: (*Refer to the Instructions for additional information.)*

☐ **Monthly premium billing.** You are required to use the ACH payment process for monthly billing. **ACH through an owned company or employer account is prohibited.** See ACH payment process described below.

* TAA (Trade Adjustment Assistance) recipients (see section "H. Eligibility, option "2".) must choose the monthly premium billing option if coordinating premium credits with HCTC (Health Coverage Tax Credit). The ACH billing process will not apply. For the TAA monthly credit, send your monthly MCHA premium invoice to HCTC.

☐ **Quarterly premium billing. Choose one of the following options:**

- ❑ **Payment by check.** A check for the full quarterly premium (3 months) is due on the first day of each calendar quarter (January through March, April through June, July through September, and October through December). Payment should be by personal check, money order or cashier's check. **Company checks are accepted only if applicant is the owner or co-owner of a business and such business does not provide an employer health plan.**
- ❑ **ACH Payment.** See ACH payment process described below.

INITIALS:_____

Note: Whether you choose the monthly or quarterly premium billing option, remember to attach your first premium payment with this application [a month's premium (1 month) or a full quarter's premium (3 months) per your elected payment option above]. You must submit your first premium payment with this application or your application will be considered incomplete and will be returned to you.

ACH Payment Process:

For the monthly or quarterly ACH process, complete the "ACH Authorization Agreement" below and attach a voided check or savings account deposit slip below. **A checking account deposit slip is NOT acceptable.**

ACH (Automated Clearing House) Authorization Agreement

The Minnesota Comprehensive Health Association (MCHA) through its administrator, Medica, is hereby authorized to deduct my MCHA premium payment due them by electronic debit entries to my checking or savings account indicated below.

Name of Account Holder			
Bank Name			Account Type *(check one)*: ❑ Checking ❑ Savings
Bank Address	City	State	Zip Code

Signature of Account Holder(s):

Account Holder Name (Print)	Account Holder Name (Print)
X _____ _____ Account Holder Signature Date	**X** _____ _____ Account Holder Signature Date

ATTACH A VOIDED CHECK OR SAVINGS ACCOUNT DEPOSIT SLIP HERE

A checking account deposit slip is NOT acceptable

L. Agent Information: *Required information for agent assisted applications*

The Minnesota licensed agent of record receives a one (1)-time $50 referral fee from MCHA upon acceptance of the application and receipt of the first premium payment.

1. Name (please print): Jamie Williams	2. MN Health Insurance License No. and Expiration Date: License No: 20310795 Exp date: 10/09
3. Issue Payment to (if different then above) MN Health Coverage, Inc.	4. Tax ID or Social Security Number:
5. Street Address: 2920 Bryant Avenue South #107	6. Telephone: 612-870-8099
7. City, State, Zip Code: MPLS, MN 55408	8. E-mail: Fax:
9. Agent's Signature:	10. Date:

Agent Certification of Health Related Rejection: *Required information if applicant is applying under section "H. Eligibility: 4. Health Related Rejection" item "b."*

1. Medical Condition and Approximate Date(s) of Diagnosis	2. Name and Address of Attending Physician

3. Name and Address of Insurer or Health Maintenance Organization (HMO) that will NOT accept the applicant:

4. I am an insurance producer licensed by the Minnesota Department of Commerce. I certify that the information I have provided is true and correct and I understand that the Minnesota Comprehensive Health Association (MCHA) will rely upon the information I have provided in determining whether or not the applicant is eligible for coverage.

INITIALS:_____

Agent's Signature:	Date:

M. Check List: *Required Information*

Incomplete applications will be delayed and the effective date may change if all required information and documentation is not received. All applicable questions must be answered, all required documentation must be included and applicable premium payment must be included for an application to be considered complete.

- ☐ I have chosen a "Plan Option" *(section A).*
- ☐ I have attached documentation verifying that I have an address and residence in Minnesota for the six (6) month period preceding application to MCHA *(section C).*
- ☐ I have completed the "Tobacco Designation" section *(section D).*
- ☐ I have attached the required documentation needed for eligibility *(section H).*
- ☐ If requesting a waiver of the six (6) month pre-existing condition limitation, I have applied for and have attached the required documentation proving eligibility for a waiver *(section I).*
- ☐ I have read and signed the "Applicant's Disclosure Authorization and Declaration" section *(section J).*
- ☐ I have enclosed a check or money order payable to MCHA for a month's premium (1 month) or a full quarter's premium (3 months), (per my elected payment option), and if electing ACH, completed the "ACH Authorization Agreement" and have attached a voided check or savings account deposit slip *(section K).*
- ☐ I have completed all required applicable sections.
- ☐ I have read and initialed all items noted by "Initial:_____ ."

Checklist is completed by: _____ X_____ _____

Print Name Signature Date