Colorado Choice Health Plans

700 Main Street, Suite 100
Alamosa, CO 81101
719-589-3696
Fax: 719-589-4901
www.cochoice.com

2016 Individual Application Cover Sheet

Directions: Please complete this application in its entirety using blue or black ink. You may select one plan per family unless applying separately. Your signature is required on pages 3 and 4 of the Colorado Uniform Individual Application as well as the Automatic Bank Draft Form (if applicable). Please contact your broker or call our sales team at (800) 475-8466 with any questions.

Please choose from the following available plans:

☐ ValueChoice 100

☐ BronzeChoice 3500/50
☐ BronzeChoice HSA 3500/50
☐ BronzeChoice 6000/50
☐ Bronze Value 50
☐ Bronze Basic 50
☐ Bronze Simple HSA

☐ SilverChoice 1750/40
☐ SilverChoice 2000/40
☐ SilverChoice 3000/30
☐ SilverChoice 2000/Copay
☐ Silver Value 70
☐ Silver Basic 60
☐ SilverChoice HSA 1500/30

☐ GoldChoice 500/30
☐ GoldChoice 1000/20
☐ GoldChoice 1500/20

Please choose from the available payment options:

☐ Monthly by automatic bank draft (from your checking account monthly)
You must complete the Automatic Bank Draft Authorization form.
If applying within 30 days of requested effective date you must include a check for your first month's premium.

☐ Monthly by check (you will be provided payment coupons)
You must include a check for your first month's premium with your application.

Please provide information for your current Primary Care Physician :
For additional applicants, please provide this information on page 4 of the Uniform Application.

Primary Applicant Name	Physician Name	City	Phone Number

Please sign and date confirming your selections:

Signature	Date

Colorado Choice Health Plans

Automatic Bank Draft Authorization

SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME	M.I.	HOME PHONE		
SUBSCRIBER'S ADDRESS		APT NO	CITY	ST	ZIP
BILLING NAME (IF DIFFERENT)			BILLING PHONE # (IF DIFFERENT)		
BILLING ADDRESS (IF DIFFERENT)		APT NO	CITY	ST	ZIP
NAME OF BANK OF FINANCIAL INSTITUTION			CITY	ST	ZIP
NAME(S) SHOWN ON ACCOUNT TO BE DEBITED			ACCOUNT NUMBER TO BE DEBITED*		
SIGNATURE(S) SHOWN ON ACCOUNT TO BE DEBITED			ROUTING NUMBER*		

*This can be found on any check from the correct account

123456789 Routing Number | 123456 Account # | 0001

I hereby authorize Colorado Choice Health Plans to debit the account shown above my (the subscriber's) Colorado Choice Health Plans health coverage when my premium payment comes due. I authorize the bank or financial institution shown above to accept such debits without responsibility for their correctness. I may terminate this Automatic Bank Draft Authorization at any time by giving Colorado Choice Health Plans, or the bank or financial institution noted above written notification of termination. I understand that such notification will become effective after Colorado Choice Health Plans, or the bank or financial institution noted above has received the notification of termination and has had a reasonable amount of time to act on it.

If the premium amount of my (the subscriber's) Colorado Choice Health Plans, health coverage should change for any reason, Colorado Choice Health Plans, will notify me in writing at least thirty (30) calendar days before the next premium is to be debited to the account.

BANK DRAFT EFFECTIVE DATE (IF NEW APPLICANT, THIS MUST MATCH YOUR MEDICAL POLICY REQUESTED EFFECTIVE DATE)		
SUBSCRIBER'S SIGNATURE	ADDITIONAL SIGNATURE (IF ANY)	DATE

Division of Insurance

COLORADO UNIFORM INDIVIDUAL APPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's initial application for coverage. Please contact your carrier with questions regarding this form.

Federal financial assistance may be available for coverage purchased through Connect for Health Colorado. If purchasing coverage through Connect for Health Colorado, you will need to provide additional information for determination of eligibility for federal financial assistance. Further information may be found at www.connectforhealthco.com.

COVERAGE INFORMATION

Application Type:	☐New Coverage ☐Change/Modification to Existing Coverage ☐Open Enrollment ☐Special Enrollment*
Requested Effective Date:	_________/_________/_________ (MM/DD/YYYY)

* Proof of eligibility for special enrollment will be required – information on eligibility for special enrollment periods is available at: www.dora.colorado.gov/DOI/HealthApp

PRIMARY APPLICANT/INSURED INFORMATION

Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.

First Name:		Middle Initial:		Last Name:			
Social Security #:		Date of Birth:	/ /	Current Age:		Sex:	☐M F☐
Physical Address:				City:			
County:		State:		Zip:			
Mailing Address (If different):				City:			
County:		State:		Zip:			
Home Phone:		Alternate Phone:		Email:			

Are you (check one): ☐ Single ☐ Married ☐ Common Law* ☐ Civil Union* ☐ Legally Separated ☐ Divorced ☐ Under 21

Are you or is anyone in your family American Indian or Alaskan Native? ☐Yes ☐No

* A common law, civil union, or designated beneficiary certification may be required by the carrier

Employer Name and Address:		Work Phone:	

ADDITIONAL APPLICANTS

Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26(older if medically disabled) are applying for coverage. If a dependent child is applying an as individual rather than as part of a family list the child as the primary applicant. If there is not enough space provided, please attach additional family information. **Please sign and date the additional sheet.**

*Social Security Numbers (or document numbers for any legal immigrants) are needed for anyone applying for health insurance, missing numbers will be requested after enrollment

Name (First, MI, Last)	Sex	Social Security #	Relationship	Disabled	Birth Date (MM/DD/YY)	Employer Name and Position
	☐M ☐F		SPOUSE/PARTNER			
	☐M ☐F		☐CHILD ☐STEPCHILD	☐ Yes ☐ No		
	☐M ☐F		☐CHILD ☐STEPCHILD	☐ Yes ☐ No		
	☐M ☐F		☐CHILD ☐STEPCHILD	☐ Yes ☐ No		

Do(es) the child(ren) named within the application live with you at the same physical address shown above? ☐Yes ☐No (if no, complete below)

Child(ren)'s Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Primary Applicant Name:

Name of the Legal Guardian or Parent responsible for carrying health insurance for the child:							
If the primary applicant is under the age of 21 if different from above, provide the name and mailing address of the legal guardian or custodial parent:							
Legal Guardian or Custodial Parent's Name:				Mailing Address (If different):			
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

TOBACCO USE

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."

Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		

MEDICARE/MEDICAID INFORMATION

Is any applicant enrolled in Medicare? ☐ Yes ☐ No

Name of person covered by Medicare: ___________________________________. For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program? ☐ Yes ☐ No

Name of person covered by Medicaid or other governmental health program: ___________________________________. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? ☐ Yes ☐ No

(Dental Coverage in next Section)

Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type

If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted? ☐ Yes ☐ No

Type of Coverage Key: **G** = Group Comprehensive Major Medical; **I** = Individual Comprehensive Major Medical; **MS** = Medicare Supplement; **H** = Hospital Coverage Only; **V** = Vision Coverage Only **O**=Other, please explain:_______________________________

Primary Applicant Name:

CERTIFICATION OF DENTAL INSURANCE COVERAGE (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required provide proof that you have obtained coverage before this policy will be approved

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved. (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)

I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I would like to receive all policy notices, premium notices, and other notices relating to this policy through the supplied email address above. ☐Yes ☐No

I understand I can change this designation at a later date by contacting my carrier directly, and understand it is my responsibility to notify my carrier of any changes to my email address.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	**Date Signed:**
Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:

Primary Applicant Name:

AGENT/PRODUCER INFORMATION

This section is to be completed by Agent or Producer.

Agent / Agency of Record: (for commissions and correspondence)	Writing Agent / Producer:
Name (print):	Name (print):
Agent ID # (NPR):	Agent ID #(NPR):

Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐Yes ☐No

As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature.

Writing Agent Signature	**Date**

DISCLOSURES

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://www.dora.colorado.gov/insurance. For questions regarding coverage or enrollment please see your carrier.

This section may be used to provide additional information that was required in the sections above and did not fit in the space provided.

Signature of Primary Applicant: ____________________ Date Signed: ____________