

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 health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage

To help us process your application promptly, please remember to:

- Print all answers in blue or black ink. Pencil will not be accepted.
- Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line.
- 3 If it is necessary to correct any errors, simply cross o what is incorrect and write your initials next to the correct information.
- 4 Please do not use correction fluid or tape.

Please submit an application via one of the following methods. If submitting by mail or fax, please complete the entire application and select a premium mode in Section D.

If you are working with a Community Health Choice Agent, please remember to include the name of your agent on the back of this application.

APPLY BY MAIL	Community Health Choice - Attn	n: Sales Department, 2	636 South Loop West, Ste. 125, Houston, Texas 77054
APPLY VIA FAX	713-295-7015	APPLY VIA EMAIL	MarketPlace@CommunityCares.com

If you have any questions, please call your insurance agent or a member of our sales team at 713-295-6704 or toll-free at 1-855-315-5386.

Please answer the following questions only if you are applying outside of the annual open enrollment period. Open Enrollment is from 11/1/2019-12/15/2019

I am requesting enrollment outside of the annual enrollment period because I have experienced one or more of these events during the last 60 days. (check all that apply and supply supporting documentation):

☐ 1. I GAINED A DEPENDENT DUE TO MARRIAGE ON	DATE
☐ 2. I GAINED A DEPENDENT DUE TO BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION ON	DATE
☐ 3. I AM NO LONGER ELIGIBLE AS A DEPENDENT UNDER MY PRIOR HEALTH INSURANCE PLAN DUE TO REACHING THE MAXIMUM AGE, LEGAL SEPARATION, DIVORCE, OR DEATH OF THE POLICYHOLDER AS OF	DATE
☐ 4. I AM NO LONGER ELIGIBLE FOR MY PRIOR HEALTH INSURANCE PLAN DUE TO TERMINATION OF EMPLOYMENT, REDUCTION IN NUMBER OF HOURS OF EMPLOYMENT, LOSS OF EMPLOYER CONTRIBUTION TOWARD MY PREMIUMS, OR I HAVE EXHAUSTED MY COBRA BENEFITS AS OF	DATE
☐ 5. I GAINED ACCESS TO NEW HEALTH PLAN OPTIONS BECAUSE OF A PERMANENT MOVE ON	DATE
☐ 6. I AM NO LONGER RESIDING OR LIVING IN MY PRIOR HEALTH INSURANCE PLAN'S HMO SERVICE AREA AS OF	DATE

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□ 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
□ 11. OTHER QUALIFYING EVENT AS REQUIRED OR PERMITTED BY APPLICABLE LAWS. PLEASE SPECIFY HERE:	DATE

Section A: Applicant(s)

PRIMARY APPLICANT □ NEW COVERAGE □ ADD DEPENDENT □ CHANGE IN COVERAGE □ TERMINATE/CANCEL COVERAGE					
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DO YOU HAVE A PREFERRED WRITT IF YES, PLEASE SPECIFY:	EN LANG	UAGE BESIDI	ES ENGLISH? Y		
*WITHIN THE PAST SIX MONTHS, HA' EXCLUDING RELIGIOUS OR CEREMO					
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MAILING ADDRESS STREET, CITY, STATE, ZIP IF DIFFERENT THAN ABOVE					
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OTHER PHONE			CAN WE SEND YO	OU TEXT MESSAGE	S? YN
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	EMAIL POSTAL MAIL				
PRIMARY CARE PHYSICIAN (FOR HMO ONLY)					
DO YOU HAVE A DISABILITY AFFECT	ING YOUF	R ABILITY TO	COMMUNICATE OF	R READ? (FOR HMC	ONLY) Y N
IF "YES," DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:					
OBSTETRICIAN OR GYNECOLOGIST	(FOR HM	O ONLY)			

Applicant Name _	
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SPOUSE AND/OR DEPENDENT CHILL	JKEN IO	BE COVERED/TERMEI	D (dependent children must be unde	er age 26)
FIRST NAME, MIDDLE INITIAL, LAST I	NAME		RELATIONSHIP	
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SOCIAL SECURITY NUMBER		DATE OF BIRTH		
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EXCLUDING RELIGIOUS OR CEREMO	ONIAL USI	ES)? Y N IF YES, PLE	EASE PROVIDE DATE OF LAST U	SE:
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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 Health Choice HMO Bronze High Deductible Health Plan HSA Compatible - 008	\$6,750 Individual/\$13,500 Family
Community Health Choice HMO BRONZE DEDUCTIBLE - 003	\$7,150 Individual/\$14,300 Family
Community Health Choice HMO SILVER DEDUCTIBLE - 009	\$5,000 Individual/\$10,000 Family
Community Health Choice HMO SILVER DEDUCTIBLE - 004	\$3,000 Individual/\$6,000 Family
Community Health Choice HMO GOLD DEDUCTIBLE - 005	\$750 Individual/\$1,500 Family
PLAN SELECTION	COPAY
Community Health Choice HMO GOLD COPAY - 001	\$30 PCP/\$65 Specialist

For HMO Only:

ATTENTION FEMALE MEMBERS: In selecting your PCP, remember that your PCP's network may affect your choice of OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your PCP.

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 DRAFT DATE 15th 25th
AUTHORIZATION AGREEMENT
Required for Bank Draft Payments Only
I request and authorize Community Health Choice and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the financial institution named below to accept and honor the same to my account. I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer—sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium or provide reimbursement for any part of the premium now or in the future. I also understand that both the financial institution and Community Health Choice reserve the right to terminate this payment program and/or my participation therein. To make changes to my financial institution I understand that I will need to provide at least 10 days advance notice to Community Health Choice by telephone prior to a scheduled withdrawal date. I understand I am responsible for ensuring the payment is processed successfully.
Please complete the following – print or type information
I authorize Community Health Choice to deduct the premium payments from my checking or savings account. If the draft date falls on a non–business day or a holiday, the premium payment will be deducted from my account on the next business day.
Please ensure adequate funds are available at the time of application. Community Health Choice is not responsible for

COPY OF VOIDED CHECK ATTACHED:

DEPOSITOR'S ACCOUNT NUMBER

RELATIONSHIP TO APPLICANT

PLEASE CHECK ONE: CHECKING ACCOUNT SAVINGS ACCOUNT

NAME AND LOCATION OF BANK WHERE ACCOUNT IS AUTHORIZED

NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT

I HAVE READ AND ACCEPT THE ABOVE AGREEMENT

BANK TRANSIT NUMBER / ROUTING NUMBER

6

TODAY'S DATE

NAME ON ACCOUNT

DEPOSITOR'S SIGNATURE

		SSN#	
CREDIT CARD (VISA, MASTERCARD, DISCOVER)			
Credit Card includes initial and ongoing payments. Payment will the Authorization Agreement below. (Check all that apply)	be drafte	d upon receipt of this a	pplication. You must complete
FIRST MONTH'S PREMIUM RECURRING MONTHLY	FIRST MONTH'S PREMIUM RECURRING MONTHLY RECURRING DRAFT DATE 15th 25th		
TOTAL AMOUNT DUE PREMIUM AMOUNT DUE O	THER AN	MOUNT	
AUTHORIZATION AGREEMENT			
Required for Bank Draft Payments Only			
I request and authorize Community Health Choice and/or its descharges to my account in the form of checks, share drafts, or ele institution named below to accept and honor the same to my accemployer group health plan and is not intended, in any way, to be employer(s) of those applying for coverage will not contribute an the premium now or in the future. I also understand that both the right to terminate this payment program and/or my participation that I will need to provide at least 10 days advance notice to Corwithdrawal date. I understand I am responsible for ensuring the page of the same to my acceptance and the premium of t	ectronic de count. I un e an emp y part of the financial therein. To mmunity I	ebit entries, and I requenderstand that this requenced by the second requested the premium or provide institution and Communion make changes to my Health Choice by telept	est and authorize the financial lest for coverage is not an insurance plan. I certify the reimbursement for any part of unity Health Choice reserve the financial institution I understand none prior to a scheduled
Please complete the following – print or type information			
I authorize Community Health Choice to deduct the premium pay falls on a non–business day or a holiday, the premium payment			
Please ensure adequate funds are available at the time of appears incurred due to insufficient funds.	plicatio	n. Community Health	Choice is not responsible for
NAME ON CREDIT CARD (EXACTLY AS PRINTED)			
BILLING ADDRESS FOR CREDIT CARD (STREET, APT #)	CITY, S	TATE, ZIP	
CREDIT CARD NUMBER	EXPIRA	TION DATE	CVV CODE
SIGNATURE		TODAY'S DATE	
Bill all charges to the above card(s). Since the payment amount date of the next charge prior to each scheduled date. This authorization is valid until I provide you with written or verba			otification of the amount and
CHECK			
		th ENGLOS	SED V N (Oh a sk all that a rack)
MONTHLY BY CHECK FIRST MONTH PREMIUM AMC MAKE CHECKS PAYABLE AND MAIL TO:	JUNI OF	\$ ENCLOS	SED Y N (Check all that apply)
Community Health Choice, Inc. PO Box 844124 Dallas, TX 75284-4124			
*Must include subscriber ID number			
NOTE: Cashing of the premium deposit does not constitute approval of this application. If this application is not approved, the premium deposit will be returned to the primary applicant and neither the primary applicant			

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Applicant Name ___

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"
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)

Applicant Name

SSN#

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?		
Y N IF "YES," PLEASE COMPLETE THE FOLLOWING:		
APPLICANT NAME	NAME ON PREVIOUS POLICY IF APPLICABLE	MEMBER/GROUP NUMBER (OPTIONAL)
APPLICANT NAME	NAME ON PREVIOUS POLICY IF APPLICABLE	MEMBER/GROUP NUMBER (OPTIONAL)

REPLACEMENT OF COVERAGE			
WILL THIS COVERAGE REPLACE ANY HEALTH COVERAGE CURRENTLY IN FORCE?			
Y N IF "YES," READ THE STATEMENT BELOW AND COMPLETE THE FOLLOWING:			
LIST ALL COVERAGE THAT WILL BE REPLACED			
INSURED	NAME OF COMPANY	POLICY NUMBER	TERMINATION DATE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS COVERAGE

If "Yes" is indicated above, you intend to lapse or otherwise terminate existing accident and sickness coverage and replace it with a contract to be issued by Community Health Choice. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the coverage protection available to you under the new contract.

- 1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- 2. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning any person applying for coverage. Failure to include all material information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
- 3. It is recommended that you not terminate your present contract until you are certain that your application for the new contract has been accepted by Community Health Choice.

Applicant Name	
SSN#	

Section E: Required Signatures

Acknowledgments: The applicant, to the best of his/her knowledge and belief, represents and agrees as follows:

- 1. This application does not provide coverage of any kind unless approval is provided by Community Health Choice (the Company); and the application, if not previously approved or declined, will be considered withdrawn on the 60th day after its date.
- 2. Medical expense coverage will not be available until the effective date of the health contract and payment, in full, of the first month's premium.
- 3. No agent can accept risks or modify policies or requirements of the Company.
- 4. The Company is not bound by any statement not written in this application.
- 5. If a spouse and/or dependent(s) is/are included for medical expense coverage, the premium will be calculated based on the age of each individual covered, subject to applicable law and regulations.
- 6. I understand that an act, practice, or omission that constitutes fraud or making an intentional misrepresentation of material fact on application may result in rescission of coverage. Rescission is defined as a cancellation of discontinuance of coverage that has a retroactive effect. I will be provided with at least 30 days' advance written notice before my or my dependent's coverage may be rescinded, retroactive to the effective date of coverage. The undersigned applicant furthers acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an Individual Policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such Individual Policy. The undersigned further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid the agent by the Company in connection with the issuance of the Individual Policy, they should contact the agent.
- 7. The Primary Applicant resides, lives, works in the Service Area. The Service Area includes the following counties: Brazoria, Fort Bend, Galveston, Harris, Jefferson, Liberty, Montgomery, Orange, Waller, Hardin, Austin, San Jacinto, Jasper, Newton, Tyler, Matagorda, Polk, Walker and Wharton.

Agreement: I understand that any statement and answers on this application are representations. To the best of my knowledge and belief they are true and complete. These representations are the basis of my application. I understand that coverage will be effective following payment in full of the first month's premium. The undersigned applicant and agent acknowledge that the application has read the completed application and that he/she realizes that any false statement material to the risk or misrepresentations therein may result in loss of coverage under the policy. This application will become a part of the contract between the Company and the applicant.

Authorization: I authorize any medical professional, hospital, clinic or other medical or medically related facility, governmental agency, pharmacy benefit manager, retail pharmacy, pharmacy clearinghouse or other person or firm to disclose to the Company or their authorized representation information, including copies of records concerning advice care or treatment provided to me and/my dependents, including and without limitation, information relating to the prescription and use of drugs or alcohol. I also authorize the release of information as needed to medical entities related to my care.

I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and will no longer be protected by the federal privacy laws.

This authorization is valid for two years from today or until I terminate coverage. I understand that I have the right to revoke the authorization at any time, in writing, by contacting Community Health Choice. I further understand that I or any authorized representative will receive a copy of this authorization upon request. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

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 not sponsor an employee health plan, neither my employer nor I deduct any part of the premium from gross income under section 106 or section 162 of the Internal Revenue Code. The Disclosure statement will be provided upon request.

The Disclosure Statement will be provided upon request.

For up to two (2) years from the effective date of the policy, when Community Health Choice is entitled to rescind coverage already in force or is otherwise permitted to make retroactive changes to this policy, Community Health Choice may at its option reform the policy already in force and/or change the rating category/level. In the event of reformation, the policy will be reissued retroactively in the form it would have been issued had the misstated or omitted information been known at the time of application.

PRIMARY APPLICANT'S SIGNATURE		DATE
SPOUSE'S SIGNATURE (IF APPLYING)†		DATE
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)		DATE
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)		DATE
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)		DATE
IF THIS AUTHORIZATION IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHA PARENT FOR A MINOR CHILD, COMPLETE THE FOLLOWING:	HALF OF AN INDIVIDUA	AL OTHER THAN
PERSONAL REPRESENTATIVE'S NAME (PLEASE PRINT)	RELATIONSHIP:	

Section F: Agent Information

AGENT'S CERTIFICATION Agent's Certification: I certify that I sent the application to the applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the applicant(s) not contained in this application and that written material explaining the benefits, exclusions, and provisions of the contract was sent to the applicant(s). I certify that I have delivered the Required Outline of Coverage, and if requested, the Disclosure Statement. **APPLICANT** POLICY(IES) SHOULD BE MAILED TO **AGENT AGENT INFORMATION (if applicable)** AGENT'S SIGNATURE DATE AGENT ID / NPN NUMBER PRINT AGENT'S NAME AGENT'S PHONE AGENT'S FAX

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Applicant Name	
SSN#	

Section G: HMO Disclosure

Texas Department of Insurance Required Disclosure Notice for all Individual HMO Consumer Choice Benefit Plans Issued in Texas

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Health Benefit Plan that I am purchasing does not include all state-mandated health insurance benefits. I understand that the following benefits are provided at a reduced level from what is mandated or excluded completely from the plan.

MANDATED BENEFIT DESCRIPTION	BENEFIT REDUCED	BENEFIT EXCLUDED
An HMO can only charge a deductible for services rendered outside of the HMO's service area or out-of-network.	Community Health Choice will apply a deductible to all services except: [preventive care] [preventive care, primary office visits, specialist care visits], urgent care and generic drugs] [preventive care, primary office visits, urgent care and generic drugs]	

I also understand that if I purchase a health plan that excludes or reduces coverage for a certain condition, I may be limiting my ability to obtain individual insurance coverage for that condition in the event the health of any individual covered under the plan changes. I understand that I may obtain addition information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.texas.gov/consumer/index.html or by calling 1-800-252-3439.

SIGNATURE OF APPLICANT	NAME OF APPLICANT PRINT NAME	DATE
BILLING ADDRESS STREET, CITY, STATE, ZIP (NO P.O. BOXES)		

Note: This form must be retained by the carrier issuing the policy and must be provided to the Commissioner of Insurance upon request. You have the right to a copy of this written disclosure free of charge. A new form must be completed upon each subsequent renewal of this policy.

Thank you for applying.

Please include all necessary materials when submitting this application.

If legal guardian, please enclose signed court decree.

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LANGUAGE ASSISTANCE

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



NON-DISCRIMINATION STATEMENT (MARKETPLACE)

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 people or treat them differently because of race, color, national origin, age, disability, or sex. Community Health Choice, Inc. provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats). Community Health Choice, Inc. provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Community Health Choice, Inc. Member Services Department at 1.855.315.5386. If you believe that Community Health Choice, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance.

You can file a grievance in person or by mail, fax or email:

Service Improvement Department

2636 South Loop West, Suite 125 Houston, Texas 77054

Phone: 1.855.315.5386

Email: ServiceImprovement@CommunityHealthChoice.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1.800.368.1019, 800.537.7697 (TDD)

Arabic

يتضمن هذا الإشعار معلومات مهمة. وتتعلق هذه المعلومات الهامة في الإشعار بخصوص طلبك أو التغطية تحت التأمين الصحي Community Health Choice ، بحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتحاذا إجراءات قبل مواعيد محددة للحفاظ على تأمينك الصحي أو مساعدتك في دفع التكاليف. لديك الحق في الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة اتصل على 155.388.

English

This Notice has Important Information. This notice has important information about your application or coverage through Community Health Choice. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1.855.315.5386.

German

Diese Mitteilung enthält wichtige Informationen. Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag auf Krankenversicherung bzw. Ihren Versicherungsschutz mit Community Health Choice. Achten Sie auf wichtige Termine in dieser Mitteilung. Eventuell müssen Sie zu bestimmten Stichtagen Ma nahmen ergreifen, um die Beibehaltung Ihres Versicherungsschutzes bzw. finanzieller Unterstützung in Ihrer Sprache. Rufen Sie an unter 1.855.315.5386.

Hindi

इस सुचना में महत्वपूर्ण जानकारी है। इस सुचना में आपके आवेदन या Community Health Choice द्वारा कवरेज के बारे में महत्ववपूरण जानकारी है। इस सुचना में महत्वपूरण तारीक्षों के लिए खोजिय। आपको अपने स्वास्प्य के कवरेज रखने के लिए या जागत की मदद के लिए निश्चल समय सीमा से कार्रवार्ड करने की ज़रूरत हो सकती है। आपको अपनी भाषा में यह जानकारी और सहायता निश्चलुक एपपल करने का अधीकार है। 1.855,315,5386 पर कॉल कीजिए।

Korean

이 통지서는 중요한 정보를 담고 있습니다. 이 통지서는 Community Health Choice를 통한 귀하의 신청이나 보험보장에 대해 중요한 정보를 담고 있습니다. 이 통지서에서 주요 날짜를 확인하십시오. 귀하의 건강보험 보장을 유지하거나 비용에서 도움을 받기 위해서는 일정한 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는, 이러한 정보를 받고 무료로 귀하의 언어로 도움을 받을 권리가 있습니다. 1.855.315.5386로 연락하십시오.

Persian

این اطلاعیه حاری اطلاعات مهمی می باشد. این اطلاعیه حاوی نکات مهمی درباره نقاضانامه و پوشش بیمه ای شما توسط -Com munity Health Choice می باشد. به تاریخ های نکر شده در این اطلاعیه توجه نمایید. به منظور برقرار نگیناشتن پوشش بیمه ای با دریافت کمک هزیفه، ممکن است نیاز باشد که تا مهات های مقرر ، اقداماتی را انجام دهید حق شماست که این اطلاعات و کمک را بطور رایگان به زبان خودتان دریافت نمایید. با شماره تلفن،315.538.53.53. تماس بگیرید.

Spanish or Spanish Creole

Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Community Health Choice. Preste atención a las fechas clave que se incluyen en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al teléfono 1.855.315.5386.

Urdu

اس نوٹس میں اہم معلومات ہیں. اس نوٹس میں Community Health Choice کے ذریعے اب کی درخواست یا ہیمے کی تحفظ سے متعلق اھم معلومات ہیں- اس نوٹس میں اہم تاریخوں کو دیکھیے – اپنی محت کے ہیمے کے تحفظ کو ہرقرار رکھنے یا اخراجات میں مدد کے لیے آپ کو کچھ خاص تاریخوں تک کارروائی کرنے کی ضورت ہوسکتی ہیں. آپ کو ان معلومات اور مدد کو اپنی زبان میں مفت حاصل کرنے کا حق حاصل ہے. 1.855.315.5335 پر رابطہ کریں.

Chinese

本通知有重要信息。本通知包含關于您透過Community Health Choice提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前采取行動,以保留您的健康保險或費用補貼。您有權免費以您的母語得到本訊息和幫助。請撥電話1.855.315.5386。

French

Cet avis contient d'importantes informations. Cet avis contient d'importantes informations concernant votre demande ou votre couverture avec Community Health Choice. Consultez les dates figurant dans le présent avis car il est possible que vous ayez à prendre certaines mesures avant ces dates pour conserver votre assurance santé ou profiter de meilleurs coûts. Vous êtes en droit de recevoir ces informations et de bénéficier gratuitement d'une aide dans votre langue. Appelez le 1.855.315.5386.

Guiarati

આ નોટિસિમાં મહત્વની માહિતી છે. આ નોટિસિમાં Community Health Choice દ્વારા તમારી અરજી અને કવરેજ વશિમહત્વનીજાણકારીછે. આનોટિસિમાંમહત્વનીતારીખોમાંટેજુઓ.તમારાઆરોગ્યકવેજનેરાખવાઅથવાખર્યબાબતે મદદકરવામાંટેઅમુક ચોક્કસ મુદત સુધી પગલાંવેવાનીતમારેજરૂરપડી શકેછે. તમને કોઈપણ ખર્યવનાતમારીભાષામાં આ જાણકારી અને મદદ મેળવવાની અધકાર છે. 1.855.315.5386 પર કોવ કરો.

Japanese

こと通知には必要な情報が含まれています。この通知にはCommunity Health Choiceの申請または補償 範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください、健康 保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希 望の言語による情報とサポートが無料で提供されます。1.855.315.5386までお電話ください。

Laotiar

ກາສີດ ງານີ້ມີຂໍ້ມູນທີ່ສາໝາສີເຈົ້ງນນີ້ມີຂໍ້ມູນທີ່ສາ ນັກ ໃຫ້ປາກໝາ້າຫຼືກາຄຸ້ມສອກ າໂຄ ເຜິ່ງນວກການໄປ Half Chook ທີ່ຊອກ ກຂໍ້ມູນວັນທີ່ທີ່ສາຄັນພາກັງສືແຈ້ງການນີ້ທ່າງຄວນຈະຕ້ອງປະ ຕິບັດມະໃນກັນ ໂດລາເພື່ອທີ່ຈຮັກສານຄຸ້ມຄອກ ຂໍພາມອງທ່ານມະຫຼັງການຊ່ວຍຫຼື ອີພິສີ ອຸຄຳຊີຈຸ ໝັນປັນສີເທື່ອງທ່ານທີ່ຈໄດ້ຮັບຂໍ້ມູນສຄັນນີ້ແຕກນຊ່ວຍຫຼື ອີພສອອງທຳນົນບໍ່ແຍຄ່ ໃນຕສັບ 1.855.315.5386.

Russian

Настоящее уведомление содержит важную информацию. Настоящее уведомление содержит важную информацию о вашем заявлении или страховом покрытии, предоставляемым Соттипиту Health Сhoice. Обратите внимание на основные даты, указанные в настоящем уведомлении. Возможно, будет необходимо предпринять действия до наступления конечного срока для сохранения страхового полиса или для получения помощи в оплате расходов. Вы имеете право на бесплатное получение этой информации и помощи на вашем языке. Звоните по телефону: 1.855.315.5386.

Tagalog

Ang Notisyang ito ay naglalaman ng Importanteng Impormasyon. Maayroon itong importanteng impormasyon tungkol sa inyong aplikasyon o pagpapaseguro sa pamamagitan Community Health Choice. Hanapin ang mga importanteng petsa sa notisyang ito. Maaaring may kailangan kayong gawin bago ang mga itinakdang deadline para manatiling nakaseguro o para matulungan kayo sa mga kailangang babayaran. Kayo ay may karapatang makatanggap nitong impormasyon at makatanggap ng pagsasalin sa inyong wika na wala kayong babayaran. Tawagan ang 1.855.315.5386.

Vietnames

Thông báo này có Thông Tin Quan Trọng. Thông báo này có thông tin quan trọng về mẫu đơn của bạn hoặc bảo hiểm qua chương trình Community Health Choice. Xem những ngày quan trọng trong thông báo này. Bạn có thể cần phải thực hiện trong thời gian nhất định để giử bảo hiểm sức khỏe của bạn hay giúp đỡ chi phí. Bạn có quyền được thông tin này và giúp đỡ trong ngôn ngữ của mình miễn phí. Xin gọi 1.855.315.5386.