



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:

- |   |   |
|---|---|
| 1 | Print all answers in blue or black ink. Pencil will not be accepted.  |
| 2 | 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 out 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.**

|                      |  |                        |                                       |
|----------------------|--|------------------------|---------------------------------------|
| <b>APPLY BY MAIL</b> | Community Health Choice - Attn: Sales Department, 2636 South Loop West, Ste. 125, Houston, Texas 77054 |                        |                                       |
| <b>APPLY VIA FAX</b> | 713-295-7015   | <b>APPLY VIA EMAIL</b> | MarketPlace@CommunityHealthChoice.org |

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 11/1/2020-12/15/2020.**

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):

|  |      |
|--|------|
| <input type="checkbox"/> 1. I GAINED A DEPENDENT DUE TO MARRIAGE ON  | DATE |
| <input type="checkbox"/> 2. I GAINED A DEPENDENT DUE TO BIRTH, ADOPTION, PLACEMENT FOR ADOPTION OR SUBJECT OF A SUIT FOR ADOPTION ON   | DATE |
| <input type="checkbox"/> 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 PLAN HOLDER AS OF  | DATE |
| <input type="checkbox"/> 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 |
| <input type="checkbox"/> 5. I GAINED ACCESS TO NEW HEALTH PLAN OPTIONS BECAUSE OF A PERMANENT MOVE ON  | DATE |

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|  |      |
|--|------|
| <input type="checkbox"/> 6. I AM NO LONGER RESIDING OR LIVING IN MY PRIOR HEALTH INSURANCE PLAN'S HMO SERVICE AREA AS OF   | DATE |
| <input type="checkbox"/> 7. AN ERROR OCCURRED IN MY PREVIOUS HEALTH PLAN ENROLLMENT ON   | DATE |
| <input type="checkbox"/> 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 |
| <input type="checkbox"/> 9. I AND/OR MY DEPENDENTS LOST MINIMUM ESSENTIAL COVERAGE DUE TO REASONS OTHER THAN NON-PAYMENT OF PREMIUM OR RESCISSION ON                         | DATE |
| <input type="checkbox"/> 10. COURT ORDER   | DATE |
| <input type="checkbox"/> 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

FIRST NAME, MIDDLE INITIAL, LAST NAME

SOCIAL SECURITY NUMBER

SEX

 M  F

DATE OF BIRTH

STATUS:

 MARRIED  SINGLE DIVORCED  WIDOWEDARE YOU A U.S. CITIZEN?  Y  NARE YOU AN ELIGIBLE NON-CITIZEN?  Y  NDO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH?  Y  N

IF YES, PLEASE SPECIFY:

DO YOU HAVE A PREFERRED WRITTEN LANGUAGE BESIDES ENGLISH?  Y  N

IF YES, PLEASE SPECIFY:

\*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)?  Y  N IF YES, PLEASE PROVIDE DATE OF LAST USE:

RESIDENTIAL ADDRESS STREET, CITY, STATE, ZIP (NO P.O. BOXES) COUNTY

COUNTY

MAILING ADDRESS STREET, CITY, STATE, ZIP IF DIFFERENT THAN ABOVE

PRIMARY PHONE

SECONDARY PHONE

CAN WE SEND YOU TEXT MESSAGES?  Y  NCAN WE SEND YOU TEXT MESSAGES?  Y  N

OTHER PHONE

CAN WE SEND YOU TEXT MESSAGES?  Y  N

EMAIL ADDRESS

PREFERRED CONTACT METHOD

 EMAIL  POSTAL MAIL

PRIMARY CARE PHYSICIAN (FOR HMO ONLY)

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY)  Y  N

IF "YES," DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

OBSTETRICIAN OR GYNECOLOGIST (FOR HMO ONLY)

Applicant Name \_\_\_\_\_

SSN# \_\_\_\_\_

**SPOUSE AND/OR DEPENDENT CHILDREN TO BE COVERED/TERMED (dependent children must be under age 26)**

|   |   |               |
|---|---|---------------|
| FIRST NAME, MIDDLE INITIAL, LAST NAME   |   | RELATIONSHIP  |
| SOCIAL SECURITY NUMBER  | SEX<br><input type="checkbox"/> M <input type="checkbox"/> F                                    | DATE OF BIRTH |
| ARE YOU A U.S. CITIZEN? <input type="checkbox"/> Y <input type="checkbox"/> N   | ARE YOU AN ELIGIBLE NON-CITIZEN? <input type="checkbox"/> Y <input type="checkbox"/> N          |               |
| *WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE PROVIDE DATE OF LAST USE: |   |               |
| *MAILING ADDRESS - STREET, CITY, STATE, ZIP IF DIFFERENT THAN ABOVE   |   | COUNTY        |
| PRIMARY PHONE   |   |               |
| CAN WE SEND YOU TEXT MESSAGES? <input type="checkbox"/> Y <input type="checkbox"/> N  |   |               |
| EMAIL ADDRESS   | PREFERRED CONTACT METHOD<br><input type="checkbox"/> EMAIL <input type="checkbox"/> POSTAL MAIL |               |
| PRIMARY CARE PHYSICIAN (FOR HMO ONLY)   |   |               |
| DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) <input type="checkbox"/> Y <input type="checkbox"/> N<br>IF "YES," DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:                      |   |               |
| OBSTETRICIAN OR GYNECOLOGIST (FOR HMO ONLY)   |   |               |

|   |   |               |
|---|---|---------------|
| FIRST NAME, MIDDLE INITIAL, LAST NAME   |   | RELATIONSHIP  |
| SOCIAL SECURITY NUMBER  | SEX<br><input type="checkbox"/> M <input type="checkbox"/> F                                    | DATE OF BIRTH |
| ARE YOU A U.S. CITIZEN? <input type="checkbox"/> Y <input type="checkbox"/> N   | ARE YOU AN ELIGIBLE NON-CITIZEN? <input type="checkbox"/> Y <input type="checkbox"/> N          |               |
| *WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE PROVIDE DATE OF LAST USE: |   |               |
| *MAILING ADDRESS - STREET, CITY, STATE, ZIP IF DIFFERENT THAN ABOVE   |   | COUNTY        |
| PRIMARY PHONE   |   |               |
| CAN WE SEND YOU TEXT MESSAGES? <input type="checkbox"/> Y <input type="checkbox"/> N  |   |               |
| EMAIL ADDRESS   | PREFERRED CONTACT METHOD<br><input type="checkbox"/> EMAIL <input type="checkbox"/> POSTAL MAIL |               |
| PRIMARY CARE PHYSICIAN (FOR HMO ONLY)   |   |               |
| DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) <input type="checkbox"/> Y <input type="checkbox"/> N<br>IF "YES," DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:                      |   |               |
| OBSTETRICIAN OR GYNECOLOGIST (FOR HMO ONLY)   |   |               |

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**SPOUSE AND/OR DEPENDENT CHILDREN TO BE COVERED/TERMED (dependent children must be under age 26)**

|   |   |   |
|---|---|---|
| FIRST NAME, MIDDLE INITIAL, LAST NAME   |   | RELATIONSHIP  |
| SOCIAL SECURITY NUMBER  | SEX<br><input type="checkbox"/> M <input type="checkbox"/> F                                    | DATE OF BIRTH   |
| ARE YOU A U.S. CITIZEN? <input type="checkbox"/> Y <input type="checkbox"/> N   |   | ARE YOU AN ELIGIBLE NONCITIZEN? <input type="checkbox"/> Y <input type="checkbox"/> N |
| *WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE PROVIDE DATE OF LAST USE: |   |   |
| *MAILING ADDRESS - STREET, CITY, STATE, ZIP IF DIFFERENT THAN ABOVE   |   | COUNTY  |
| PRIMARY PHONE   |   |   |
| CAN WE SEND YOU TEXT MESSAGES? <input type="checkbox"/> Y <input type="checkbox"/> N  |   |   |
| EMAIL ADDRESS   | PREFERRED CONTACT METHOD<br><input type="checkbox"/> EMAIL <input type="checkbox"/> POSTAL MAIL |   |
| PRIMARY CARE PHYSICIAN (FOR HMO ONLY)   |   |   |
| DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) <input type="checkbox"/> Y <input type="checkbox"/> N<br>IF "YES," DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:                      |   |   |
| OBSTETRICIAN OR GYNECOLOGIST (FOR HMO ONLY)   |   |   |

|   |   |   |
|---|---|---|
| FIRST NAME, MIDDLE INITIAL, LAST NAME   |   | RELATIONSHIP  |
| SOCIAL SECURITY NUMBER  | SEX<br><input type="checkbox"/> M <input type="checkbox"/> F                                    | DATE OF BIRTH   |
| ARE YOU A U.S. CITIZEN? <input type="checkbox"/> Y <input type="checkbox"/> N   |   | ARE YOU AN ELIGIBLE NONCITIZEN? <input type="checkbox"/> Y <input type="checkbox"/> N |
| *WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE PROVIDE DATE OF LAST USE: |   |   |
| *MAILING ADDRESS - STREET, CITY, STATE, ZIP IF DIFFERENT THAN ABOVE   |   | COUNTY  |
| PRIMARY PHONE   |   |   |
| CAN WE SEND YOU TEXT MESSAGES? <input type="checkbox"/> Y <input type="checkbox"/> N  |   |   |
| EMAIL ADDRESS   | PREFERRED CONTACT METHOD<br><input type="checkbox"/> EMAIL <input type="checkbox"/> POSTAL MAIL |   |
| PRIMARY CARE PHYSICIAN (FOR HMO ONLY)   |   |   |
| DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) <input type="checkbox"/> Y <input type="checkbox"/> N<br>IF "YES," DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:                      |   |   |
| OBSTETRICIAN OR GYNECOLOGIST (FOR HMO ONLY)   |   |   |

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                                      | COPAY                              |
|---|------------------------------------|
| <input type="checkbox"/> Community Elite Gold HSA14 | \$2,000 Individual/ \$4,000 Family |

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 15th  DRAFT DATE 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. To the extent my employer is contributing to any part of the premium, either directly or through reimbursement, it is through a [QSEHRA, or ICHRA.] 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 fees incurred due to insufficient funds.**

PLEASE CHECK ONE:  CHECKING ACCOUNT  SAVINGS ACCOUNT

NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT  COPY OF VOIDED CHECK ATTACHED:

NAME AND LOCATION OF BANK WHERE ACCOUNT IS AUTHORIZED

NAME ON ACCOUNT

BANK TRANSIT NUMBER / ROUTING NUMBER

DEPOSITOR'S ACCOUNT NUMBER

I HAVE READ AND ACCEPT THE ABOVE AGREEMENT

DEPOSITOR'S SIGNATURE

TODAY'S DATE

RELATIONSHIP TO APPLICANT

Applicant Name \_\_\_\_\_

SSN# \_\_\_\_\_

 **CREDIT CARD (VISA, MASTERCARD, DISCOVER)**

Credit Card 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      RECURRING DRAFT DATE  15th  25th

TOTAL AMOUNT DUE  PREMIUM AMOUNT DUE  OTHER AMOUNT

**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. To the extent my employer is contributing to any part of the premium, either directly or through reimbursement, it is through a [QSEHRA, or ICHRA.] 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 fees incurred due to insufficient funds.**

NAME ON CREDIT CARD (EXACTLY AS PRINTED)

BILLING ADDRESS FOR CREDIT CARD (STREET, APT #)

CITY, STATE, ZIP

CREDIT CARD NUMBER

EXPIRATION DATE

CVV CODE

SIGNATURE

TODAY'S DATE

Bill all charges to the above card(s). Since the payment amount may vary, I will receive written notification of the amount and date of the next charge prior to each scheduled date.

This authorization is valid until I provide you with written or verbal cancellation.

 **CHECK**

MONTHLY BY CHECK  FIRST MONTH PREMIUM AMOUNT OF \$      ENCLOSED  Y  N (Check all that apply)

MAKE CHECKS PAYABLE AND MAIL TO:

**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

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)

**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 PLAN IF APPLICABLE | MEMBER/GROUP NUMBER (OPTIONAL) |
| APPLICANT NAME | NAME ON PREVIOUS PLAN 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 | PLAN 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 \_\_\_\_\_

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## 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 further 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 Plan, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such Individual Plan. 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 Plan, they should contact the agent.
7. The Primary Applicant resides, lives, works in the Service Area. The Service Area includes the following counties: Brazoria, Chambers, 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 plan. 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

For up to two (2) years from the effective date of the plan, when Community Health Choice is entitled to rescind coverage already in force or is otherwise permitted to make retroactive changes to this plan, Community Health Choice may at its option reform the plan already in force and/or change the rating category/level. In the event of reformation, the plan 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 BEHALF OF AN INDIVIDUAL OTHER THAN A PARENT FOR A MINOR CHILD, COMPLETE THE FOLLOWING: |               |
| 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.

PLAN(S) SHOULD BE MAILED TO  AGENT  APPLICANT

### AGENT INFORMATION (if applicable)

|                    |               |                       |
|--------------------|---------------|-----------------------|
| AGENT'S SIGNATURE  | DATE          | AGENT ID / NPN NUMBER |
| PRINT AGENT'S NAME | AGENT'S PHONE | AGENT'S FAX           |

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 utilize deductible for all services except for preventive care. |                  |
|  |  |                  |

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](http://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 plan 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 plan.

# Thank you for applying.

Please include all necessary materials when submitting this application.

If legal guardian, please enclose signed court decree.

# 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](mailto: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

يضمن هذا الإشعار معلومات مهمة. وتتعلق هذه المعلومات الهامة في الإشعار بخصوص طلبك أو التغطية تحت التأمين الصحي بضمن Community Health Choice. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ 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 1.855.315.5386.

### 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 Maßnahmen ergreifen, um die Beibehaltung Ihres Versicherungsschutzes bzw. finanzieller Unterstützung in Ihrer Sprache. Rufen Sie an unter 1.855.315.5386.

### Hindi

इस सूचना में महत्वपूर्ण जानकारी है। इस सूचना में आपके आवेदन या Community Health Choice द्वारा कवरेज के बारे में महत्वपूर्ण जानकारी है। इस सूचना में महत्वपूर्ण तारीखों के लिए खोजें। आपको अपने स्वास्थ्य के कवरेज रखने के लिए या लागत की मदद के लिए नशित समय सीमा से कार्रवाई करने की ज़रूरत हो सकती है। आपको अपनी भाषा में यह जानकारी और सहायता नि:शुल्क प्राप्त करने का अधिकार है। 1.855.315.5386 पर कॉल कीजिए।

### Korean

이 통지서는 중요한 정보를 담고 있습니다. 이 통지서에서 주요 날짜를 확인하십시오. 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. 1.855.315.5386 로 연락하십시오.

### Persian

این اطلاعیه حاوی اطلاعات مهمی می باشد. این اطلاعیه حاوی نکات مهمی درباره تقاضای شما و پوشش بیمه ای شما توسط Community Health Choice می باشد. به تاریخ های ذکر شده در این اطلاعیه توجه نمایید. به منظور برقرار نگه داشتن پوشش بیمه ای یا دریافت کمک هزینه، ممکن است نیاز باشد که تا مهلت های مقرر، اقداماتی را انجام دهید. حق شماست که این اطلاعات و کمک را بطور رایگان به زبان خودتان دریافت نمایید. به شماره تلفن 1.855.315.5386 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 آپ کی درخواست یا بیمہ کی تحفظ سے متعلق اہم معلومات ہیں۔ اس نوٹس میں اہم تاریخوں کو دیکھیں۔ اپنی صحت کے لیے یا اخراجات میں مدد کے لیے آپ کو کچھ خاص تاریخوں تک کارروائی کرنے کی ضرورت ہوسکتی ہے۔ آپ کو ان معلومات اور مدد کو اپنی زبان میں مفت حاصل کرنے کا حق حاصل ہے۔ 1.855.315.5386 پر رابطہ کریں۔

### Chinese

本通知有重要信息。本通知包含關於您透過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採取行動，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.

### Gujarati

આ નોટિસમાં મહત્વની માહિતી છે. આ નોટિસમાં Community Health Choice દ્વારા તમારી અરજી અને કવરેજ વર્ષી મહત્વની જાણકારી છે. આ નોટિસમાં મહત્વની તારીખો માટે જુઓ. તમારા આરોગ્ય કવરેજને રાખવા અથવા ખર્ચ વાળને મદદ કરવા માટે અધિક ચોક્કસ મુદત સુધી પગલાં લેવાની તમારે જરૂર પડી શકે છે. તમને કોઈ પણ ખર્ચ વગેરે તમારી ભાષામાં આ જાણકારી અને મદદ મેળવવાની અધિકાર છે. 1.855.315.5386 પર કોલ કરો.

### Japanese

この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。

### Laotian

ທັງສີແຈງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນ. ທັງສີແຈງການນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການສະໜັບສະໜູນກູ້ຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ Community Health Choice. ໃຫ້ຂອບການຂໍ້ມູນອັນທີ່ສໍາຄັນໃນທັງສີແຈງການນີ້ ທ່ານຄວນຈະຖອດປະຕິບັດພາຍໃນກໍາລັດເວລາເພື່ອທີ່ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານພາຍຫຼັງການຊ່ວຍເຫຼືອໃນເລື່ອງຕ່າງໂຊ່າ ຯ. ມັນເປັນສິດທິຂອງທ່ານທີ່ຈະໂຕ້ຮົບຂໍ້ມູນສໍາຄັນນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທລະສັບ: 1.855.315.5386.

### Russian

Настоящее уведомление содержит важную информацию. Настоящее уведомление содержит важную информацию о вашем заявлении или страховом покрытии, предоставляемом Community Health Choice. 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 kailalang babayaran. Kayo ay may karapatang makatanggap nitong impormasyon at makatanggap ng pagsasalain sa inyong wika na wala kayong babayaran. Tawagan ang 1.855.315.5386.

### Vietnamese

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 giữ 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.