COMMUNITY HEALTH CHOICE

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.

APPLY BY MAIL	Community Health Choice - Attn: Sales Department, 2636 South Loop West, Ste. 125, Houston, Texas 77054		
APPLY VIA FAX	713-295-7015	**APPLY VIA EMAIL**	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 11/1/2021-1/15/2022.

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, PLACEMENT FOR ADOPTION OR SUBJECT OF A SUIT 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 PLAN HOLDER 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

Applicant Name _____

SSN# _____

☐ 6. I AM NO LONGER RESIDING OR LIVING IN MY PRIOR HEALTH INSURANCE PLAN'S HMO SERVICE AREA AS OF	DATE
☐ 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

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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 ☐ WIDOWED

ARE YOU A U.S. CITIZEN? Y N

ARE YOU AN ELIGIBLE NON-CITIZEN? Y N

DO 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

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

PRIMARY PHONE CAN WE SEND YOU TEXT MESSAGES? Y N	SECONDARY PHONE CAN 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)

*Age 18 and over

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 M F	DATE OF BIRTH	
ARE YOU A U.S. CITIZEN? Y N		ARE YOU AN ELIGIBLE NON-CITIZEN? Y N	
*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:			
*MAILING ADDRESS - STREET, CITY, STATE, ZIP IF DIFFERENT THAN ABOVE			COUNTY
PRIMARY 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)			

FIRST NAME, MIDDLE INITIAL, LAST NAME			RELATIONSHIP
SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH	
ARE YOU A U.S. CITIZEN? Y N		ARE YOU AN ELIGIBLE NON-CITIZEN? Y N	
*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:			
*MAILING ADDRESS - STREET, CITY, STATE, ZIP IF DIFFERENT THAN ABOVE			COUNTY
PRIMARY 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)			

*Age 18 and over

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 M F	DATE OF BIRTH
ARE YOU A U.S. CITIZEN? Y N		ARE YOU AN ELIGIBLE NONCITIZEN? Y N
*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:		
*MAILING ADDRESS - STREET, CITY, STATE, ZIP IF DIFFERENT THAN ABOVE		COUNTY
PRIMARY 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)		

FIRST NAME, MIDDLE INITIAL, LAST NAME		RELATIONSHIP
SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH
ARE YOU A U.S. CITIZEN? Y N		ARE YOU AN ELIGIBLE NONCITIZEN? Y N
*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:		
*MAILING ADDRESS - STREET, CITY, STATE, ZIP IF DIFFERENT THAN ABOVE		COUNTY
PRIMARY 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)		

*Age 18 and over

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
☐ 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 _____

SSN# _____

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 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. Making an intentional misrepresentation of material fact 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 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, or 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 applicant 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

Thank you for applying.

Please include all necessary materials when submitting this application.

If legal guardian, please enclose signed court decree.

COMMUNITY HEALTH CHOICE

Consumer Choice Plan Disclosure Statement

This health plan does not include the same level of benefits required in other plans.

This HMO plan is a consumer choice plan. This plan doesn't include the same level of benefits that are in Texas health plans known as state-mandated plans. This plan does include all health benefits required by the Affordable Care Act.

To see all benefits offered by this plan, go to the plan's "Summary of Benefits and Coverage."

Benefit/coverage:	**This plan:**	**A health plan with required benefits (state-mandated plan):**
Deductible The amount you pay for care before the plan begins to share the cost.	Has a deductible.	Has no deductibles for in-network care.
Out-of-pocket costs The amount you pay when you receive care, up to an annual limit.	Includes out-of-pocket costs that meet federal requirements but may sometimes be more than in a state-mandated plan.	A copay must be less than 50% of the total cost of the service. Annual out-of-pocket costs must be capped at 200% of your annual premium cost if you alert the plan.
Habilitative and Rehabilitative care Care that helps you improve skills for daily living.	Includes a limit of combined 35 visits per year for chiropractic care.	Has no limit on the amount of care if it is needed for medical reasons.
Home Health Services	Includes a limit of 60 visits per year.	Has no limit on the amount of care that is ordered by your doctor.
Skilled Nursing Facility	Includes a limit of 25 visits per year.	Has no limit on the amount of care that is ordered by your doctor.

If you want a plan with all required benefits:

We also offer a state-mandated plan that includes all required benefits. This plan is not on Healthcare.gov and does not allow you to get help with premiums and out-of-pocket costs.

To learn more about this plan, call 1-855-315-5386 or visit https://www.communityhealthchoice.org.

By signing your application to enroll in this plan, you acknowledge the following:

- I understand the consumer choice plan I am applying for does not provide the same level of coverage required in other Texas health plans (state-mandated plans).
- I understand if my health changes and this plan does not meet my needs, in most cases I won't be able to get a new plan until the next open enrollment period.
- I understand I can get more information about consumer choice plans from the Texas Department of Insurance's website, www.tdi.texas.gov/consumer/consumerchoice.html, or by calling the Consumer Help Line at 1-800-252-3439.

Don't sign this document if you don't understand it.
No firme este documento si no lo comprende.

Print the name of the person applying: _____
Signature of the person applying: _____
Date of signature: _____
Name of business, if applicable: _____ _____

Community Health Choice must give you a copy of this statement upon request.

LANGUAGE ASSISTANCE

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

COMMUNITY HEALTH CHOICE

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. 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 Ma nahmen 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 खोजिये। आपको अपने स्वास्थ्य के कवरेज रखने के लिए या लागत की मदद के लिए निश्चित समय सीमा से कार्रवाइड करने की ज़रूरत हो सकती है। आपको अपनी भाषा में यह जानकारी और सहायता निःशुल्क प्राप्त करने का अधिकार 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 حاوی اطلاعات مهمی می باشد. این اطلاعیه حاوی نکات مهمی درباره تقاضانامه و پوشش بیمه ای شما توسط Community Health Choice می باشد. به تاریخ های ذکر شده در این اطلاعیه توجه نمایید. به منظور برقرار نگهداشتن پوشش بیمه ای با 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. با 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 بیمے کی تحفظ سے متعلق اہم معلومات ہیں- اس نوٹس میں اہم تاریخوں کو دیکھیے – اپنی صحت کے بیمے کے تحفظ کو برقرار رکھنے یا اخراجات میں مدد کے لیے آپ کو کچھ خاص تاریخوں تک کارروائی کرنے کی ضرورت ہوسکتی ہیں. 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.

Gujarati

આ નોટિસમાં મહત્વની માહિતી છે. આ નોટિસમાં Community Health Choice દ્વારા તમારી અરજી અને કવરેજ વિશે મહત્વની જાણકારી છે. આ નોટિસમાં મહત્વની તારીખો માટે જુઓ. તમારા આરોગ્ય કવરેજને રાખવા અથવા ખર્ચ બાબતે મદદ કરવા માટે અમુક ચોક્કસ મુદત સુધી પગલાં લેવાની તમારે જરૂર પડી શકે છે. તમને કોઈ પણ ખર્ચ વિના તમારી ભાષામાં આ જાણકારી અને મદદ મેળવવાનો અધિકાર છે. 1.855.315.5386 પર કોલ 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。

Laotian

ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ. ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ Community Health Choice. ໃຫ້ຊອກຫາຂໍ້ມູນວັນທີ່ທີ່ສຳຄັນໃນໜັງສືແຈ້ງການນີ້ ທ່ານຄວນຈະຕ້ອງປະຕິບັດພາຍໃນກຳນົດເວລາເພື່ອທີ່ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານພາຍໃຫ້ງການຊ່ວຍເຫຼືອໃນເລື່ອງຄ່າໃຊ້ຈ່າຍ. ມັນເປັນສິດທິຂອງທ່ານທີ່ຈະໄດ້ຮັບຂໍ້ມູນສຳຄັນນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທລະສັບ: 1.855.315.5386.

Russian

Настоящее уведомление содержит важную информацию. Настоящее уведомление содержит важную информацию о вашем заявлении или страховом покрытии, предоставляемым 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 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.

Vietnamese

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 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.