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, 4888 Loop Central Drive, Ste. 600, Houston, Texas 77081 | | |
| **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 11/1/2024-1/15/2025.**

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 |

# 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 | COUNTY |
|---|---|

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

| PRIMARY PHONE<br>CAN WE SEND YOU TEXT MESSAGES? Y N | SECONDARY PHONE<br>CAN WE SEND YOU TEXT MESSAGES? Y N |
|---|---|
| OTHER PHONE | CAN WE SEND YOU TEXT MESSAGES? Y N |
| EMAIL ADDRESS | PREFERRED CONTACT METHOD<br>☐ 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 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<br>CAN WE SEND YOU TEXT MESSAGES? Y N | | | |
| EMAIL ADDRESS | | | PREFERRED CONTACT METHOD<br>☐ 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<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 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<br>CAN WE SEND YOU TEXT MESSAGES? Y N | | | |
| EMAIL ADDRESS | | | PREFERRED CONTACT METHOD<br>☐ 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<br>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<br>CAN WE SEND YOU TEXT MESSAGES? Y N | | |
| EMAIL ADDRESS | | PREFERRED CONTACT METHOD<br>☐ 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<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 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<br>CAN WE SEND YOU TEXT MESSAGES? Y N | | |
| EMAIL ADDRESS | | PREFERRED CONTACT METHOD<br>☐ 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<br>IF "YES," DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED: | | |
| OBSTETRICIAN OR GYNECOLOGIST (FOR HMO ONLY) | | |

Applicant Name _____

SSN# _____

**NOTICE TO APPLICANT REGARDING WRITTEN COMMUNICATION BEING DELIVERED ELECTORONICALLY**

| WRITTEN COMMUNICATION DELIVERED ELECTRONICALLY | |
|---|---|
| If you indicate "Yes" in this section and provided an email address in Section A above, you will receive all communications including your plan documents electronically at the email provided. Plan documents may also be viewed and printed anytime, you can find all documents on your Online Account. You can request a paper copy of any written communication by calling Customer Service at the number listed on your Member ID or Logging into your Online Account. You can also change your preferred contact method to receive written communications method or provide updated contact information anytime by calling Customer Service at the number listed on your Member ID Card or logging into your Online Account. | Y N |
| PRIMARY APPLICANT'S SIGNATURE | DATE |

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 Premier Gold 001** | $30PCP/$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<br>☐ RECURRING 15th ☐ DRAFT DATE 25th | | |
| **AUTHORIZATION AGREEMENT**<br>**Required for Bank Draft Payments Only**<br>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. 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.<br>**Please complete the following – print or type information**<br>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.<br>**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. 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 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 AS A DEPENDENT?<br>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?<br>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, 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
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 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.



*Age 18 and over

# LANGUAGE ASSISTANCE

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

COMMUNITY HEALTH CHOICE

## NON-DISCRIMINATION STATEMENT (MARKETPLACE)

**Discrimination is Against the Law**

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 or treat people differently because of race, color, national origin, age, disability or sex.

**Community Health Choice, Inc.:**

- Provides free aids and services to people with disabilities so that they can communicate effectively with us, such as:
  - Qualified sign-language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

Community Health Choice, Inc. also trains staff to be mindful of cultural differences in communication styles, body language, and decision-making processes.

If you need these services, contact our Member Services Department at 1.855.315.5386 or TDD/TTY 711.

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 with:

**Community Health Choice**
Attn: Service Improvement Department
4888 Loop Central Drive, Suite 600
Houston, Texas 77081

**Phone:** 1.855.315.5386 TDD/TTY 711
**Fax:** 713.295.7036
**Email:** ServiceImprovement@CommunityHealthChoice.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, call 713.295.6704 or email MemberServices@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

**Phone:** 1.800.368.1019, 800.537.7697 (TDD)
**Complaint forms are available at** http://www.hhs.gov/ocr/office/file/index.html

**Arabic** العربية

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.855.315.5386.

**Chinese**

注意：如果　使用繁體中文，　可以免費獲得語言援助服務。請致電 1.855.315.5386

**English**

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1.855.315.5386.

**French**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez 1.855.315.5386.

**German**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.855.315.5386.

**Gujarati**

**સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** 1.855.315.5386.

**Hindi**

**ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।** 1.855.315.5386 **पर कॉल करें।**

**Japanese**

注意事項：日本語を話される場合、
無料の言語支援をご利用いただけます。1.855.315.5386まで、お電話にてご連絡ください。

**Korean**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.855.315.5386번으로 전화해 주십시오

**Lao**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.855.315.5386.

**Persian**

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با 1.855.315.5386 تماس بگیرید.

**Russian**

ВНИМАНИЕ:  Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.  Звоните 1.855.315.5386.

**Spanish**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.855.315.5386.

**Tagalog**

PAUNAWA:  Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.  Tumawag sa 1.855.315.5386.

**Urdu**

توجہ: اگر آپ اردو زبان بولتے ہیں تو آپ کے لیے مفت میں زبان کی مدد کی خدمات دستیاب ہیں۔ 1.855.315.5386 پر کال کریں۔

**Vietnamese**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.855.315.5386.