

Applicant Name	
SSN#	
Member ID	
Effective Date	
Cancellation Date	

# Individual Plan

# New Application or Change in Coverage

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

1	Print all answers in b	lue or black ink.	Pencil will not be	accepted
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- 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 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 11/1/2025-12/15/2025.

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 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 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

SSN#	
□ 6. I AM NO LONGER RESIDING OR LIVING IN MY PRIOR HEALTH 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

Applicant Name

DATE

# **Section A:** Applicant(s)

SPECIFY HERE:

PRIMARY APPLICANT  ☐ NEW COVERAGE ☐ ADD DEPEND	ENT 🗆 C	HANGE IN COVERAGE ☐ TERM	INATE/CANCEL COV	ERAGE
FIRST NAME, MIDDLE INITIAL, LAST N	NAME			
SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH	STATUS: ☐ MARRIED ☐ S	INCL F
	MF		□ DIVORCED □ W	INGLE 'IDOWED
ARE YOU A U.S. CITIZEN? Y N		ARE YOU AN ELIGIBLE NON-CI	TIZEN? Y N	
DO YOU HAVE A PREFERRED SPOKE	N LANGL	JAGE BESIDES ENGLISH? Y N		
IF YES, PLEASE SPECIFY:				
DO YOU HAVE A PREFERRED WRITT	EN LANG	UAGE BESIDES ENGLISH? Y N		
IF YES, PLEASE SPECIFY:				
*WITHIN THE PAST SIX MONTHS, HAV		•		
EXCLUDING RELIGIOUS OR CEREMO		<u> </u>	VIDE DATE OF LAST	T .
RESIDENTIAL ADDRESS STREET, CITY, STATE, ZIP (NO P.O. BOXES) COUNTY  COUNTY				
MAILING ADDRESS STREET, CITY, ST	ATE, ZIP	IF DIFFERENT THAN ABOVE		
PRIMARY PHONE		SECONDARY PHO	NE	
CAN WE SEND YOU TEXT MESSAGES? YN CAN WE SEND YOU TEXT MESSAGES? YN				? Y N
OTHER PHONE		CAN WE SEND YO	OU TEXT MESSAGES	? Y N
EMAIL ADDRESS	EMAIL ADDRESS PREFERRED CONTACT METHOD			
☐ EMAIL ☐ POSTAL MAIL				
PRIMARY CARE PHYSICIAN (FOR HM	O ONLY)			
DO YOU HAVE A DISABILITY AFFECTI	NG YOUF	R ABILITY TO COMMUNICATE OF	R READ? (FOR HMO	ONLY) Y N
IF "YES," DESCRIBE SPECIAL COMMU	JNICATIO	N MATERIALS NEEDED:		
OBSTETRICIAN OR GYNECOLOGIST	(FOR HM	O ONLY)		

Applicant Name _	
SSN#	

SPOUSE AND/OR DEPENDENT CHILD	DREN TO I	BE COVERED/TERMED	(dependen	t children must be unde	er age 26)
FIRST NAME, MIDDLE INITIAL, LAST N	NAME		RELATION	SHIP	
SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH			
	MF				
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*WITHIN THE PAST SIX MONTHS, HAV	VE YOU U				RAGE
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PRIMARY CARE PHYSICIAN (FOR HM	IO ONLY)				
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IF "YES," DESCRIBE SPECIAL COMMU	JNICATIO	N MATERIALS NEEDED	<b>)</b> :		
OBSTETRICIAN OR GYNECOLOGIST	(FOR HM	O ONLY)			
FIDOT MAME MIDDLE INITIAL LACTA	LANAE		DEL ATION	CLUD	
FIRST NAME, MIDDLE INITIAL, LAST N	NAME		RELATION	SHIP	
			RELATION	SHIP	
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SOCIAL SECURITY NUMBER  ARE YOU A U.S. CITIZEN? Y N  *WITHIN THE PAST SIX MONTHS, HAVE EXCLUDING RELIGIOUS OR CEREMOTE  *MAILING ADDRESS - STREET, CITY, SERVING PRIMARY PHONE	SEX M F VE YOU U DNIAL USE STATE, ZI	ARE YOU AN ELIGIBL SED TOBACCO (4 OR I ES)? Y N IF YES, PLE	E NON-CIT MORE TIME ASE PROV	IZEN? Y N ES PER WEEK ON AVE	SE:
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SOCIAL SECURITY NUMBER  ARE YOU A U.S. CITIZEN? Y N  *WITHIN THE PAST SIX MONTHS, HAVE EXCLUDING RELIGIOUS OR CEREMOTE  *MAILING ADDRESS - STREET, CITY, SERVING PRIMARY PHONE	SEX M F VE YOU U DNIAL USE STATE, ZI	ARE YOU AN ELIGIBL SED TOBACCO (4 OR I ES)? Y N IF YES, PLE	E NON-CIT MORE TIME ASE PROV ABOVE	IZEN? Y N ES PER WEEK ON AVE IDE DATE OF LAST US ED CONTACT METHO	SE: COUNTY
SOCIAL SECURITY NUMBER  ARE YOU A U.S. CITIZEN? Y N  *WITHIN THE PAST SIX MONTHS, HAVE EXCLUDING RELIGIOUS OR CEREMOTE  *MAILING ADDRESS - STREET, CITY, SERIMARY PHONE  CAN WE SEND YOU TEXT MESSAGES EMAIL ADDRESS	SEX M F VE YOU U DNIAL USE STATE, ZI	ARE YOU AN ELIGIBL SED TOBACCO (4 OR I ES)? Y N IF YES, PLE	E NON-CITI MORE TIME ASE PROV ABOVE	IZEN? Y N ES PER WEEK ON AVE IDE DATE OF LAST US ED CONTACT METHO	SE: COUNTY
SOCIAL SECURITY NUMBER  ARE YOU A U.S. CITIZEN? Y N  *WITHIN THE PAST SIX MONTHS, HAVE EXCLUDING RELIGIOUS OR CEREMO  *MAILING ADDRESS - STREET, CITY, S  PRIMARY PHONE  CAN WE SEND YOU TEXT MESSAGES	SEX M F VE YOU U DNIAL USE STATE, ZI	ARE YOU AN ELIGIBL SED TOBACCO (4 OR I ES)? Y N IF YES, PLE	E NON-CIT MORE TIME ASE PROV ABOVE	IZEN? Y N ES PER WEEK ON AVE IDE DATE OF LAST US ED CONTACT METHO	SE: COUNTY
SOCIAL SECURITY NUMBER  ARE YOU A U.S. CITIZEN? Y N  *WITHIN THE PAST SIX MONTHS, HAVE EXCLUDING RELIGIOUS OR CEREMOTE  *MAILING ADDRESS - STREET, CITY, S  PRIMARY PHONE  CAN WE SEND YOU TEXT MESSAGES  EMAIL ADDRESS  PRIMARY CARE PHYSICIAN (FOR HM	SEX  M F  VE YOU U  ONIAL USE STATE, ZI  S? Y N	ARE YOU AN ELIGIBLE SED TOBACCO (4 OR I ES)? Y N IF YES, PLE P IF DIFFERENT THAN	E NON-CITI MORE TIME ASE PROV ABOVE PREFERR	IZEN? Y N ES PER WEEK ON AVE IDE DATE OF LAST US ED CONTACT METHO POSTAL MAIL	SE: COUNTY
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SOCIAL SECURITY NUMBER  ARE YOU A U.S. CITIZEN? Y N  *WITHIN THE PAST SIX MONTHS, HAVE EXCLUDING RELIGIOUS OR CEREMOTE  *MAILING ADDRESS - STREET, CITY, S  PRIMARY PHONE  CAN WE SEND YOU TEXT MESSAGES  EMAIL ADDRESS  PRIMARY CARE PHYSICIAN (FOR HM	SEX  M F  VE YOU U  ONIAL USE STATE, ZI  S? Y N  IO ONLY)  NG YOUR	ARE YOU AN ELIGIBLE SED TOBACCO (4 OR IES)? YN IF YES, PLE PIF DIFFERENT THAN	E NON-CITI MORE TIME ASE PROV ABOVE  PREFERR  EMAIL	IZEN? Y N ES PER WEEK ON AVE IDE DATE OF LAST US ED CONTACT METHO POSTAL MAIL	SE: COUNTY
SOCIAL SECURITY NUMBER  ARE YOU A U.S. CITIZEN? Y N  *WITHIN THE PAST SIX MONTHS, HAY EXCLUDING RELIGIOUS OR CEREMO  *MAILING ADDRESS - STREET, CITY, S  PRIMARY PHONE CAN WE SEND YOU TEXT MESSAGES EMAIL ADDRESS  PRIMARY CARE PHYSICIAN (FOR HM  DO YOU HAVE A DISABILITY AFFECTI IF "YES," DESCRIBE SPECIAL COMMU	SEX  M F  VE YOU U  ONIAL USE STATE, ZI  S? Y N  IO ONLY)  NG YOUR  JNICATION	ARE YOU AN ELIGIBLE SED TOBACCO (4 OR IN ES)? YN IF YES, PLE PIF DIFFERENT THAN RABILITY TO COMMUN N MATERIALS NEEDED	E NON-CITI MORE TIME ASE PROV ABOVE  PREFERR  EMAIL	IZEN? Y N ES PER WEEK ON AVE IDE DATE OF LAST US ED CONTACT METHO POSTAL MAIL	SE: COUNTY
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		Applican	t Name	
			SSN#	
SPOUSE AND/OR DEPENDENT CHILD	REN TO I	BE COVERED/TERMED	) (dependent children must be unde	er age 26)
FIRST NAME, MIDDLE INITIAL, LAST N			RELATIONSHIP	Ğ ,
SOCIAL SECURITY NUMBER	SEX	DATE OF BIRTH		
	MF			
ARE YOU A U.S. CITIZEN? Y N		ARE YOU AN ELIGIBL	E NONCITIZEN? Y N	
*WITHIN THE PAST SIX MONTHS, HAV				
EXCLUDING RELIGIOUS OR CEREMO				
*MAILING ADDRESS - STREET, CITY, S	STATE, ZI	P IF DIFFERENT THAN	ABOVE	COUNTY
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CAN WE SEND YOU TEXT MESSAGES	8? Y N			
EMAIL ADDRESS			PREFERRED CONTACT METHO	D
			EMAIL POSTAL MAIL	
PRIMARY CARE PHYSICIAN (FOR HM	O ONLY)			
IF "YES," DESCRIBE SPECIAL COMMU			):	
FIRST NAME, MIDDLE INITIAL, LAST N	IAME		RELATIONSHIP	
SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH		
ARE YOU A U.S. CITIZEN? Y N		ARE YOU AN ELIGIBL	E NONCITIZEN? Y N	
*WITHIN THE PAST SIX MONTHS, HAV				
EXCLUDING RELIGIOUS OR CEREMO				
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PRIMARY PHONE				
CAN WE SEND YOU TEXT MESSAGES	8? Y N			
EMAIL ADDRESS			PREFERRED CONTACT METHO	D
			EMAIL POSTAL MAIL	
PRIMARY CARE PHYSICIAN (FOR HM	O ONLY)			
DO VOLLHAVE A DISABILITY AFFECTIV	NG VOLIE		ICATE OD DEAD? (EOD LIMO ON	

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.	YN
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 Texas 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 coverage for a specific medical treatment or procedure to be performed in the Service Area?

Please circle: Yes / No

PLAN SELECTION	COPAY
Community Ultra Select Gold 001 Off-Exchange	\$30 PCP/\$65 Specialist

#### For HMO Only:

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

	Applicant Name	
g Information	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 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.  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.		000	NIAIT
PLEASE CHECK ONE: CHECKING ACCOUNT SAVINGS ACCOUNT  NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT  ORDER OF VOIDER CHECK ATTACHER.			
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

	SSN#		
CREDIT CARD (VISA, MASTERCARD, DISCOVER)			
Credit Card includes initial and ongoing payments. Payment w the Authorization Agreement below. (Check all that apply)	ill be drafted upon receipt of t	his application. You must complete	
FIRST MONTH'S PREMIUM RECURRING MONTHL	Y RECURRING DRAFT DA	ATE 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 d charges to my account in the form of checks, share drafts, or e institution named below to accept and honor the same to my a employer group health plan and is not intended, in any way, to of those applying for coverage will not contribute any part of th now or in the future. I also understand that both the financial in terminate this payment program and/or my participation therein will need to provide at least 10 days advance notice to Commundate. I understand I am responsible for ensuring the payment	electronic debit entries, and I account. I understand that this be an employer–sponsored be premium or provide reimbunstitution and Community Hean. To make changes to my finunity Health Choice by teleph	request and authorize the financial request for coverage is not an health plan. I certify the employer(s) resement for any part of the premium alth Choice reserve the right to ancial institution I understand that I	
Please complete the following – print or type information			
I authorize Community Health Choice to deduct the premium pfalls on a non–business day or a holiday, the premium payment			
Please ensure adequate funds are available at the time of fees incurred due to insufficient funds.  NAME ON CREDIT CARD (EXACTLY AS PRINTED)	application. Community He	alth Choice is not responsible for	
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 ver	bal cancellation.		
СНЕСК			
☐ MONTHLY BY CHECK ☐ FIRST MONTH PREMIUM AN	MOUNT OF \$ EN	CLOSED Y N (Check all that apply)	
MAKE CHECKS PAYABLE AND MAIL TO:			
Community Health Choice Texas, Inc. PO Box 411925 Boston, MA 02241-1925			
*Must include subscriber ID number	oprovol of this small-stire if	this application is not approved	
NOTE: Cashing of the premium deposit does not constitute a the premium deposit will be returned to the primary applicant applying for coverage under this application shall be entitled t	and neither the primary appli		

Applicant Name

RESPONSIBLE PARTY BILLING NAME AND ADDRESS
If different than applicant name and residential address. If an address is entered in this section, only the billing will be sent to this address; all other correspondence will be sent to the address in Section A, unless requested otherwise.
FIRST NAME, MIDDLE INITIAL, LAST NAME
BILLING ADDRESS STREET, CITY, STATE, ZIP (NO P.O. BOXES)
NAME OF BILL TO PARTY (IF REQUESTING LIST BILL ONLY)

Applicant Name

**99N#** 

# **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?			
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 health plan, 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 r	eimbursement.	
3. Since my employer does not sponsor an employee health plan, neither my employer nor income under section 106 or section 162 of the Internal Revenue Code. The Disclosure		
The Disclosure Statement will be provided upon request.		
For up to two (2) years from the effective date of the plan, when Community Health Choi force or is otherwise permitted to make retroactive changes to this plan, Community Health already in force and/or change the rating category/level. In the event of reformation, the form it would have been issued had the misstated or omitted information been known a	alth Choice may at its op e plan will be reissued re	tion reform the plan etroactively in the
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 BEI A PARENT FOR A MINOR CHILD, COMPLETE THE FOLLOWING:	HALF OF AN INDIVIDUA	AL OTHER THAN
PERSONAL REPRESENTATIVE'S NAME (PLEASE PRINT)	RELATIONSHIP:	
Section F: Agent Information		
AGENT'S CERTIFICATION		
Agent's Certification: I certify that I sent the application to the applicant(s) for completic recorded the answers as given. I further certify that I have no knowledge of any other not contained in this application and that written material explaining the benefits, exclusives sent to the applicant(s). I certify that I have delivered the Required Outline of Cove Statement.	medical information abousions, and provisions of	ut the applicant(s)
PLAN(S) SHOULD BE MAILED TO AGENT APPLICANT		
AGENT INFORMATION (if applicable)		

# Thank you for applying.

DATE

**AGENT'S PHONE** 

AGENT ID / NPN NUMBER

AGENT'S FAX

**AGENT'S SIGNATURE** 

PRINT AGENT'S NAME

Please include all necessary materials when submitting this application.

If legal guardian, please enclose signed court decree.

# **LANGUAGE ASSISTANCE**

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



### NON-DISCRIMINATION STATEMENT (MARKETPLACE)

### Discrimination is Against the Law

Community Health Choice 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 does not exclude or treat people differently because of race, color, national origin, age, disability or sex.

#### **Community Health Choice:**

- 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 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 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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.isf">https://ocrportal.hhs.gov/ocr/portal/lobby.isf</a>, 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

## قيبرعل Arabic

تامدخ ناف ، قغلل الكذا شدحتت تنك اذا : قظوحلم لصتا ناجملاب كل رفاوتت قيو غلل قدعاسمل لصتا . 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

સુયના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. કોન 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, ການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1.855.315.5386.

#### **Persian**

دینک یم وگتفگ یسراف نابز هب رگا: هجوت مهارف امش یارب ناگیار تروصب ینابز تالیهست دیریگب سامت 1.855.315.5386 اب دشاب یم

#### 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

وت ، ںیہ ہے ۔ لوب ودرا پ آ رگ ا:رادر ب خ ۔ ام دخ ی ک درم ی ک ناب زوک پ آ ۔ ای ۔ ای ۔ س د ںیم ۔ ن م ای ک ک ک ک ک ک ک ک ک ک ک ک ک کا کہ کا میں کا کہ کو کا کہ کا کا کہ کا کہ

#### 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.