



Indiana Comprehensive Health Insurance Association



Applicant Guide

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Thank you for your interest in the Indiana Comprehensive Health Insurance Association (ICHIA) healthcare coverage. ICHIA was created by the Indiana Legislature to offer an alternative for health insurance coverage to residents of Indiana who experience problems in obtaining or keeping health insurance due to a medical condition or other qualifying condition. If you have questions or would like to reach us, below is our contact information:

www.ichia.org – website

ICHIA - P.O. Box 33009, Indianapolis, IN 46203-0009 – Mailing Address

ACS - 4550 Victory Lane, Indianapolis, IN 46203 – Walk in Address (8am – 4pm)

1-800-552-7921 – toll free (8am – 4pm)

317-614-2133 – local (8am – 4pm)

SECTION I: DO YOU QUALIFY FOR ICHIA COVERAGE?

To be eligible for an ICHIA policy, you must meet **ALL** of the general requirements and **ONE** of the eligibility categories.

GENERAL REQUIREMENTS (You Must Meet All of These Requirements)

1. You must be a resident of the State of Indiana (A resident refers to a person who has resided continuously in the State of Indiana in a place of permanent habitation for at least 12 months immediately preceding application for insurance and throughout the period of your coverage). ***The residency requirement does not apply to applicants who are federally eligible.***
2. You are not eligible for Medicaid. ***The Medicaid requirement does not apply to applicants who are federally eligible.***
3. ***If you are on Medicare, you may still be eligible*** and your benefits will be coordinated with ICHIA Benefits. Options for Medicare Beneficiaries include: Plans 1, 2 and 3 medical coverage only and no pharmacy benefits – OR a choice of any plan that includes pharmacy. ICHIA is the payor of last resort and coordinates benefits with Medicare payments.

ELIGIBILITY CATEGORIES (You Must Meet ONE of These Category Requirements)

1. **Federally Eligible** - You are federally eligible if on the date you apply for coverage with ICHIA; you have had creditable coverage for at least 18 months with no lapse in coverage exceeding 63 days. Your most recent coverage must satisfy ***ALL the following requirements***: 1) have been under a group plan (through your or a family members' employer or union); 2) you are not eligible for coverage under any other group health plan; 3) you do not have other health insurance; 4) you are not eligible for Medicaid; 5) you did not lose your insurance for not paying the premiums or for committing fraud; and 6) if offered COBRA benefits, you must have exhausted your COBRA benefits. You can prove your creditable coverage with any of the following as long as they clearly establish 18 months of coverage with no lapse in coverage longer than 63 days: a copy of the Certificate of Health Plan Coverage provided by your previous insurance carrier / employer, a letter from the insurance carrier indicating your length of coverage, explanations of benefits (EOBs), other correspondence from a plan or issuer or paystubs that clearly establish 18 months of coverage with no lapse in coverage longer than 63 days. Federal eligibility is determined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 which allows individuals to avoid a pre-existing condition waiting period when changing from one carrier to another.
2. **Rejection for Other Health Coverage** - Received notification of rejection from a health insurer for coverage that equals or exceeds the MINIMUM requirements for accident or sickness insurance policies issued in Indiana.
3. **Premium Rate Higher Than ICHIA** - You received a premium notice for health insurance coverage exceeding the premium rate for coverage by ICHIA. However, you must not be eligible for any coverage that equals or exceeds the minimum requirements for accident and sickness policies in Indiana.

DEPENDENT ELIGIBILITY

Coverage for your spouse and / or children is also available based on the following Limiting Age requirement.

An unmarried dependent child's coverage will terminate on the earlier of the child's 24th birthday, or the child's 25th birthday, if the child is a full-time student in an accredited high school, technical or vocational school, or college or university and is chiefly dependent on you for support and maintenance.

Attainment of the limiting age will not terminate a child's coverage if the child is:

- Incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and
- Chiefly dependent on you for support and maintenance.

Proof of such incapacity and dependency must be furnished within 120 days of the child's attainment of the limiting age, and subsequently as ICHIA requires, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Newborn Children: Your newborn child is automatically covered for the first 31 days after birth. Coverage for the first 31 days is subject to the annual deductible, coinsurance, and out-of-pocket maximum. The coverage for newly born children consists of coverage of Injury or Illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If you wish to continue the child's coverage beyond the first 31 days and add the child as a dependent under this Policy, you must contact us before the end of the 31-day period to request a dependent application and you will be required to pay the necessary premium. If you do not add the child as a dependent, the newborn's coverage terminates at the end of the 31-day period after birth.

Adopted Children: The coverage for newly adopted children will be the same as for other dependents. Coverage for an adopted child is effective upon the earlier of:

- the date of placement for the purpose of adoption; or
- the date of the entry of an order granting you custody of the child for purposes of adoption; and continues unless the placement is disrupted prior to legal adoption and the child is removed from placement for 31 days. If you wish to continue the child's coverage beyond the first 31 days and add the adopted child as a dependent under this Policy, you must contact us before the end of the 31-day period to request a dependent application. You will be required to pay the necessary premium. If you do not add the adopted child as a dependent, the child's coverage terminates at the end of the 31-day period after adoption or placement for adoption.

Your final eligibility will be determined by Indiana Comprehensive Health Insurance Association (ICHIA) in accordance with statute IC 27-8-10-10.

ICHIA has established eligibility guidelines to prohibit: (1) employer (2) insurance agent; or (3) insurance broker from placing in or referring to ICHIA an individual who works for an employer who offers employees an employee welfare benefit plan (as defined in 29 U.S.C. 1002). Declination by the employer's carrier does not guarantee eligibility for ICHIA.

SECTION 2: WHAT ARE THE COVERED BENEFITS?

Covered Benefits can vary by plan and include various levels of Inpatient Hospital, Mental Illness and Substance Abuse, Prescription Drugs, Professional Services (office visits), Skilled Home Healthcare, Skilled Nursing Facilities, Surgical Expenses, Transplant Services, and Hospice Services.

See the benefit chart on the following pages to determine the plan differences.

If you are applying as a Medicare Beneficiary you can choose any of the Plans below for full coverage OR you can choose Plan 1, Plan 2 and Plan 3 MEDICAL BENEFITS ONLY without pharmacy coverage which on your application are designated as:

PLAN 1 Rx - THIS IS THE SAME AS PLAN 1 COVERAGE DETAILED ON THE FOLLOWING PAGES WITH MEDICARE PART D (INSTEAD OF ICHIA'S PHARMACY COVERAGE)

PLAN 2 Rx - THIS IS THE SAME AS PLAN 2 COVERAGE DETAILED ON THE FOLLOWING PAGES WITH MEDICARE PART D (INSTEAD OF ICHIA'S PHARMACY COVERAGE)

PLAN 3 Rx - THIS IS THE SAME AS PLAN 3 COVERAGE DETAILED ON THE FOLLOWING PAGES WITH MEDICARE PART D (INSTEAD OF ICHIA'S PHARMACY COVERAGE)

REFER TO THE PREMIUM RATE TABLE PAMPHLET LOCATED IN THIS PACKET TO SEE THE DIFFERENCE IN COST FOR EACH OF THESE PLANS. IF YOU ARE A MEDICARE BENEFICIARY AND WISH TO PURCHASE ONLY THE MEDICAL SERVICES OF A PLAN WITHOUT PHARMACY, PLEASE UTILIZE THE MEDICARE BENEFICIARY RATE GUIDE.

If you are enrolled in **Medicare Part A** and are not enrolled in **Medicare Part B**, you need to be aware that ICHIA will not be responsible for the dollars that Medicare would have paid had you been enrolled in **Medicare Part B**.

Medicare Part A is defined as hospital insurance which helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home healthcare and hospice care. **Medicare Part B** is defined as insurance that helps pay for doctors' services, diagnostic tests, ambulance services, durable medical equipment and other healthcare services.

The following exclusion is listed in the ICHIA policy:

- Charges Medicaid or Medicare paid, or for which Medicaid or Medicare would have been liable for, if the Insured had enrolled in those programs.

If you have **Medicare Part A** but do not have **Medicare Part B**, you can sign up for **Medicare Part B** during a general enrollment period. A general enrollment period is held January 1 through March 31 each year.

Insurance Counseling and Assistance programs are located in every state. These programs have volunteer counselors who can give you free assistance with Medicare questions, including enrollment, entitlement and premium issues. In Indiana the Senior Health Insurance Information Program (SHIIP) can assist you. They can be reached at 1-800-452-4800. You can also call 1-800-633-4227 or visit www.medicare.gov.



BENEFITS AND PLAN FEATURES		Plan 1 & Plan 1 Rx
MEDICAL DEDUCTIBLE - The portion of MEDICAL healthcare expenses a member must pay out-of-pocket before any insurance coverage applies or reimbursement by ICHIA for expenses begins.	\$500	
PHARMACY DEDUCTIBLE - The portion of PRESCRIPTION DRUGS / PHARMACY expenses a member must pay out-of-pocket before any insurance coverage applies or reimbursement by ICHIA for expenses begins. This is in addition to your MEDICAL DEDUCTIBLE UNLESS YOU CHOOSE PLAN 4. If you are a Medicare Beneficiary and want a Medical only Plan (1 Rx, 2 Rx, or 3 Rx), this does not apply to you.	\$550	NOT APPLICABLE IF YOU ARE CHOOSING THE MEDICARE PLAN THAT DOES NOT COVER Rx – PLAN 1 Rx
COINSURANCE - The set percentage of the cost of covered services that are an out-of-pocket payment by the member. The amount of coinsurance differs if you go to an in-network provider or an out-of-network provider.	You Pay 20% for in-network services. You Pay 40% for out-of-network services.	
COPAYMENT - The dollar amount you must typically pay at the time of service that is your responsibility and is based on the type of service(s) received.	Emergency Room - \$100 copay (unless you are admitted to the hospital at the time of your emergency visit).	
OUT-OF-POCKET MAXIMUM (including deductible and coinsurance) - The limit that is placed on how much the member's share of eligible expenses are per calendar year (deductible + coinsurance) before ICHIA pays 100% of eligible expenses for the remainder of the calendar year.	\$1,500	
INPATIENT & HOSPITAL SERVICES - Inpatient and Hospital Services can vary by plan. Review each plan benefit description in this chart for differences in coverage. Your deductibles and copay also apply to this benefit.	Services up to 180 days per calendar year paid at a semi-private room rate unless a private room is medically necessary.	
PROFESSIONAL SERVICES – Professional Services which are rendered by a physician for the treatment of a medical condition is the same for all plans. Your specific plan deductibles and copay applies to this benefit.	Services rendered by your Physician are covered up to policy maximums and copay of your plan.	
MENTAL ILLNESS / SUBSTANCE ABUSE – Inpatient and Outpatient Services related to Mental Illness and Substance Abuse Treatment can vary by plan. Review each plan benefit description in this chart. Your deductibles and copay also apply to this benefit.	Outpatient: 30 outpatient visits per year combined. Inpatient: Services covered in the same manner as any other illness.	
SKILLED NURSING FACILITY - As an alternative to hospital confinement, your provider may prescribe admission to a skilled nursing facility. The benefit of 180 days is the same for all plans. Your specific plan deductibles and copay applies to this benefit.	Services up to 180 days per calendar year are covered, provided confinement meets the criteria outlined in the policy. Precertification is required.	
SURGICAL EXPENSES – Surgical Expenses are expense incurred during surgery. These benefits are the same for all plans. Your specific plan deductibles and copay apply to this benefit. Second Surgical Opinion is an option in your plan elective. Plan will pay 100% of the usual and customary allowance for the second opinion.	100% of the usual and customary allowance for the second opinion.	

*Plan 5 available as of January 1, 2011.

----- PLANS AVAILABLE -----

Plan 2 & Plan 2 Rx	Plan 3 & Plan 3 Rx	Plan 4	Plan 5*
\$1,000	\$1,500	\$2,500 - Plan 4 has a shared medical and pharmacy deductible	\$5,000 - Plan 5 has a shared medical and pharmacy deductible
\$450 NOT APPLICABLE IF YOU ARE CHOOSING THE MEDICARE PLAN THAT DOES NOT COVER Rx – PLAN 2 Rx	\$550 NOT APPLICABLE IF YOU ARE CHOOSING THE MEDICARE PLAN THAT DOES NOT COVER Rx – PLAN 3 Rx	\$2,500 - Plan 4 has a shared medical and pharmacy deductible	\$5,000 - Plan 5 has a shared medical and pharmacy deductible
Same as Plan 1	Same as Plan 1	Same as Plan 1	Same as Plan 1
Same as Plan 1	Same as Plan 1	Same as Plan 1	Same as Plan 1
\$3,000	\$4,000	\$5,000	\$5,900
Services up to 365 days per calendar year paid at a semi-private room rate unless a private room is medically necessary.	Same as Plan 2	Same as Plan 1	Same as Plan 1
Same as Plan 1	Same as Plan 1	Same as Plan 1	Same as Plan 1
\$50,000 lifetime benefit for mental illness / substance abuse combined. MENTAL ILLNESS: Inpatient – 60 days / yr. Outpatient - 50 visits / yr; \$30 / visit SUBSTANCE ABUSE: Inpatient- 30 days consecutive per 365 day period. No more than two such 30 day periods during contract lifetime. Outpatient - 60 visits / lifetime.	Same as Plan 2	Same as Plan 1	Same as Plan 1
Same as Plan 1	Same as Plan 1	Same as Plan 1	Same as Plan 1
Same as Plan 1	Same as Plan 1	Same as Plan 1	Same as Plan 1

BENEFITS AND PLAN FEATURES		Plan 1 & Plan 1 Rx
SKILLED HOME HEALTHCARE – Skilled Home Healthcare Services which include home infusion therapy can vary by plan. Review each plan benefit description in this chart. Your deductibles and copay also apply to this benefit.		Services for 270 visits each calendar year (as described in the policy), but may not exceed \$150 for each day. ICHIA does not cover custodial care. Precertification applies to home infusion therapy.
PRESCRIPTION DRUGS / PHARMACY BENEFITS – Medco Administers the Pharmacy Benefits for ICHIA. Please contact Medco for additional information or a listing of the formulary drugs at www.medco.com or call Member Services at 1-877-841-5249. TTY/TDD users should call 1-800-759-1089.		Retail Location: 30 Day Supply \$16 Generic Copay \$28 Formulary Copay \$44 Non-formulary Copay Mail Order: 90 Day Supply \$40 Generic Copay \$60 Formulary Copay \$100 Non-formulary Copay NO COVERAGE IF YOU ARE CHOOSING THE MEDICARE PACKAGE WITH NO ICHIA RX (Plan 1 Rx) AND USING MEDICARE PART D AS YOUR PHARMACY COVERAGE
TRANSPLANT SERVICES - Transplant Services which are services rendered in relationship to a covered transplant can vary by plan. Your specific plan deductibles and copay apply to this benefit.		Transplant services are covered without a benefit limit.
HOSPICE SERVICES - Hospice Services include Hospice care that may be provided in the home or at a Hospice facility for end-of-life care designed to meet the member's medical, social and psychological needs. Hospice care is available for patients with a terminal illness and life expectancy of six months or less as certified by their physician. Hospice includes routine home care, continuous home care, Inpatient Hospice and Inpatient respite care. Covered Services include the following after authorization. Your specific plan deductibles and copays apply to this benefit. <ul style="list-style-type: none"> • Skilled Nursing Services (by an R.N. or L.P.N.) • Diagnostic Services • Physical, speech and inhalation therapies • Medical supplies, equipment and appliances • Counseling services, including bereavement counseling • Inpatient confinement at a hospice facility • Prescription Drugs to end disease or dying process • Respite Care 		Hospice services are covered without a benefit limit

*Plan 5 available as of January 1, 2011.

Going out of the PPO network will increase the amount of out-of-pocket expenses you

		\$100 Office Visit	
		YOU PAY	ICHIA
Out-of-Network	\$100 Office Visit <u>x 20%</u> Coinsurance \$20 You Pay	\$100 Office Visit <u>x 80%</u> Coinsurance \$80 ICHIA Pays	
	\$100 Office Visit <u>x 40%</u> Coinsurance \$40 You Pay	\$100 Office Visit <u>x 60%</u> Coinsurance \$60 ICHIA Pays	

----- PLANS AVAILABLE -----

Plan 2 & Plan 2 Rx	Plan 3 & Plan 3 Rx	Plan 4	Plan 5*
Services for 270 visits each calendar year (as described in the policy), but may not exceed \$60 for each day. ICHIA does not cover custodial care. Precertification applies to home infusion therapy.	Same as Plan 2	Same as Plan 1	Same as Plan 1
Same as Plan 1 NO COVERAGE IF YOU ARE CHOOSING THE MEDICARE PACKAGE WITH NO ICHIA RX (Plan 2 Rx) AND USING MEDICARE PART D AS YOUR PHARMACY COVERAGE	Same as Plan 1 NO COVERAGE IF YOU ARE CHOOSING THE MEDICARE PACKAGE WITH NO ICHIA RX (Plan 3 Rx) AND USING MEDICARE PART D AS YOUR PHARMACY COVERAGE	Same as Plan 1	Same as Plan 1
Benefits are limited to \$250,000 during lifetime, including payments made on your behalf to donors. ICHIA will pay eligible expenses as any other sickness and the donor's eligible expenses as if the expense was incurred by you; this includes both pre- and post-transplant expenses.	Same as Plan 2	Same as Plan 1	Same as Plan 1
Same as Plan 1	Same as Plan 1	Same as Plan 1	Same as Plan 1

you incur. The examples below illustrate how using a PPO provider saves you money.

PAYS			\$1000 Hospital Visit		
YOU PAY		ICHIA PAYS			
\$1000 Hospital Visit <u>x 20%</u> Coinsurance \$200 You Pay		\$1000 Hospital Visit <u>x 80%</u> Coinsurance \$800 ICHIA Pays			
\$1000 Hospital Visit <u>x 40%</u> Coinsurance \$400 You Pay		\$1000 Hospital Visit <u>x 60%</u> Coinsurance \$600 ICHIA Pays			

DEDUCTIBLE - The amount of allowable expenses that must be incurred and paid by you in a calendar year before benefits become payable by ICHIA. The first calendar year begins on the effective date of the policy and ends on December 31 of that same year. No more than one deductible must be satisfied by each insured during a calendar year. You may elect to change to a Plan with a higher deductible. No changes are allowed to a Plan with a lower deductible. Any Plan changes in coverage under this policy are effective January 1.

COINSURANCE - Coinsurance is the percentage of allowable expenses you pay after the deductible has been satisfied. Coinsurance amounts are **in addition to** any charges incurred due to using an out-of-network provider (such as charges over the usual and customary allowance).

OUT-OF-POCKET EXPENSE LIMIT - The out-of-pocket maximum represents the total dollar amount, including the deductible and coinsurance that you will have to pay toward allowable expenses in a calendar year. This does not include your separate pharmacy amount.

When your out-of-pocket maximum is reached in each calendar year, ICHIA will pay 100% for additional allowable expenses incurred by that insured, up to the benefit maximums, for the remainder of that calendar year. When the family out-of-pocket maximum is reached, ICHIA will pay 100% of the additional allowable expenses incurred by all insureds under this policy for the remainder of that calendar year.

SECTION 3: WHAT ARE THE EXCLUSIONS?

There are specific **Exclusions** in the policy document that can be reviewed on www.ichia.org. A summary of exclusions is provided below:

Check the exclusions before receiving services.

Cosmetic Care and Related Supplies - Any services performed in connection with cosmetic surgery for a nonfunctional condition or for any condition that existed on the effective date of the enrollee's coverage. ICHIA will cover: a) services required as a result of an injury received while insured under this policy; b) repair of congenital defects of newborn children and birth defects if the insured is under age 12 or if he / she was under age 12 when first surgically treated for the condition; c) otherwise covered medical expenses that are an integral part of such surgery; d) services required as a result of previous medically necessary surgery if the insured had uninterrupted coverage with us from the date of the previous surgery.

Custodial Care - Services or treatment which, regardless of where it is provided: a) could be rendered safely by a person without medical skills; and b) is designed mainly to help the patient with daily living activities, including (but not limited to): 1) personal care such as help in walking, getting in and out of bed; help with bathing; help with eating by spoon, tube or gastrostomy; exercising; dressing; enema; and using the toilet; 2) homemaking such as preparing meals or special diets; 3) moving the patient; 4) acting as companion or sitter; 5) supervising medication which can usually be self-administered; 6) oral hygiene; and 7) ordinary skin and nail care.

Dental Prosthetics and Surgery - Dental prosthetics and oral and dental surgery are excluded. Care or supplies received from a dental or medical department run by an employer, mutual benefit association, labor union, trust, or similar person or group to the extent you have no obligation to pay for them is also excluded.

Medicaid Charges - Charges paid by Medicaid or for which Medicaid is liable.

Experimental Drugs - Prescription drugs that are not, in the opinion of the Food and Drug Administration (FDA), scientifically proven as effective in treating the condition, diagnosis or illness for which their use is proposed.

Experimental Procedures - Healthcare services which are unproven by scientific evidence or generally not accepted by informed healthcare professionals in the U.S. as effective in treating the condition, diagnosis or illness for which their use is proposed.

Medicare Charges - Charges paid by Medicare or for which Medicare is liable.

Nursing - Private duty nursing care or services of special nurses except as outlined in the Home Healthcare section under Covered Benefits.

Pharmacy Exclusions - Please contact Medco to obtain a list of pharmacy exclusions.

Pre-existing Conditions - Any condition or illness that existed on or before the effective date of coverage with ICHIA and for which medical treatment or advice was recommended or received within a period of three months before the effective date of coverage.

Personal Comfort Items - Any personal comfort item such as televisions, barber or beauty services.

Services or Supplies - Services or supplies which are not medically necessary, medically appropriate, or are experimental in nature for the diagnosis or treatment of a specific illness.

Workers' Compensation Charges - Charges paid under Workers' Compensation or Occupational Disease Law requirements.

PRE-EXISTING CONDITIONS

A pre-existing condition is any condition or illness that existed on or before the effective date of coverage with ICHIA and for which medical treatment or advice was recommended or received within the three months before your effective date of coverage.

You qualify for a Pre-Existing Condition Waiver if you lost your health insurance coverage within six months from the date of your application for coverage with ICHIA and provide a Certificate of Creditable Coverage from your previous health insurer / employer.

If you do not qualify for the Pre-Existing Condition Waiver, ICHIA excludes payment of benefits for the first three months following the policy effective date for any injury or illness deemed a pre-existing condition. If a claim is submitted that appears to be a pre-existing illness or condition, information will be requested from your provider regarding the diagnosis to determine if any treatment or advice was given.

After the pre-existing condition waiting period of three months has been satisfied, ICHIA will cover charges related to the pre-existing condition according to your Plan's schedule of reimbursement.

If you qualify for an ICHIA policy under the Federally Eligible category, you cannot be denied coverage for a condition, based upon the fact that the condition was present before the first day of coverage, regardless of whether any medical advice, diagnosis, care or treatment was recommended or received before that day.

**Request a policy for a complete listing of exclusions by calling ACS Customer Service
or by logging on to www.ichia.org**

SECTION 4: HOW ARE THE COVERED BENEFITS MANAGED BY ICHIA?

You have a choice of 4 different benefit plans discussed in the previous section. Each of the benefit plans are managed through your ICHIA service team which include the following companies:



ACS provides all General Administration including Enrollment, Customer Service, Claims Payment, Premium Billing, and the Financial Management of the ICHIA Program.



APS Healthcare provides all Care Coordination and Authorization Services including Condition Management and Pre-Certification Services. Condition Management is part of the *ICHIA Healthy Together Program* for certain illnesses or conditions. *Healthy Together* is a free and confidential program that is required for all eligible ICHIA members with the specified illnesses or conditions.



Anthem Blue Cross and Blue Shield (Anthem)* provides the Preferred Provider Organization (PPO) of doctors and hospitals for ICHIA which represents a full range of medical specialties and includes hundreds of specialists across Indiana to provide the best medical care available. When you use a PPO provider, ICHIA will pay a higher percentage of the covered benefit costs. If you use a provider outside of the PPO, your payment responsibility will be higher.



Medco provides the Pharmacy Benefit Management Services and ICHIA members should go to one of the pharmacies in the Medco Network for prescription drugs. Members have access to a nationwide network of pharmacies which include places like your local drugstores, CVS national chains, etc. Through the Medco pharmacy locations, members will benefit from negotiated discounts on prescription drugs upon presenting their Medco pharmacy card.

*Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of Blue Cross and Blue Shield Association®. Anthem is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names are registered marks of the Blue Cross and Blue Shield Association.

SECTION 5: HOW DO I APPLY FOR ICHIA COVERAGE?

It's easy to apply.

NOTE: Steps 1 and 2 do not apply to federally eligible individuals.

Step 1: You must apply to Medicaid within 60 days prior to sending an application to ICHIA.

Step 2: Provide Proof of Medicaid Application by providing a copy of your application or verification that you have applied for Medicaid. A form is included in this packet for you to complete. You can go to www.in.gov/fssa (click on Apply for Benefits) to download a Medicaid application and eligibility information.

Step 3: Select the Plan that is right for you. Once you have determined which Plan is right for you, you can determine what your premium payment will be. Complete the enclosed application and return it with your **first two months premium** to the address on the form.

Your Employer is NOT allowed to pay your premiums. This can cause your coverage to be denied or terminated in the future.

Your effective date of coverage will be the later of: 1) the date the application is approved, 2) the day after your previous major medical coverage ends, or 3) a future date you request not to exceed 60 days.

All sections of the application must be completed in their entirety. A checklist is provided with your application to help guide you through the application process. Remember, premium payment is due at the time of application and all payments are deposited immediately upon receipt.

If at any time while completing the application you have questions, please contact our customer service department at 1-800-552-7921 or 317-614-2133.

You can also visit us on-line at www.ichia.org where you can view additional information about the ICHIA Plan or use our Ask-a-CSR inquiry system to send an electronic message to a customer service representative (CSR). If you wish to get a password for ichia.org, please call 1-800-511-5774 ext. 4444 and give the information requested.

Once your application is approved, you will receive a medical ID card, a pharmacy ID card , an out-of-state card, and other specific details about your benefits and the procedures you need to follow to get the maximum benefits to which you are entitled.





1-800-552-7921
www.ichia.org

PRINTING INSTRUCTIONS

**WHEN PRINTING THIS APPLICATION
PLEASE PRINT EACH
SHEET SEPARATELY
(DO NOT BACK-TO-BACK
ANY OF IT)**



INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

P.O. Box 33009
Indianapolis, IN 46203-0009
1-800-552-7921
317-614-2133
www.ichia.org

Dear Applicant:

Thank you for your interest in health care coverage offered by Indiana Comprehensive Health Insurance Association (ICHIA). Please complete the checklist below prior to mailing your application to ensure we receive all of the necessary information needed to process your application.

- Is your application completely filled out and signed in **black** ink?
- Did you choose a health care plan (Plan 1, 1 Rx, 2, 2 Rx, 3, 3 Rx, 4, 5)? **Application Section I.**
- Did you specify an effective date? If not, the effective date will be the date a complete and accurate application is approved. **Application Section I.**
- If you have a post office box, is a street address also included? We must have a street address to prove residency. **Application Section II.**
- If you listed dependents, do they meet the eligibility requirements listed? Have you included proof of dependency? **Application Section III.**
- Did you check an eligibility category? Did you include a copy of the documentation asked for under the category you checked? **Application Section IV.**
- Have you included proof of Indiana residency (for at least 12 months)? If a driver's license is used as proof of residency, it must be issued at least 12 months prior to the date of your application. **Application Section IV.**
- If you qualify based on rejection of other coverage or a higher premium than ICHIA**, did you identify any other health care coverage for which you or your spouse is eligible? **Application Section V.**
- If you qualify based on rejection of other coverage or a higher premium than ICHIA**, did you complete and include the proof of Medicaid Application? *You must apply for Medicaid within 60 days PRIOR to applying with ICHIA. It is not required if you are federally eligible.* **Application Section V.**
- If you qualify based on rejection of other coverage or a higher premium than ICHIA**, have you individually listed ALL medical advice, care or treatment you received in the three months preceding your application? **It is not required if you are federally eligible.** **Application Section VII.**
- If you qualify as federally eligible**, did you include a Certificate of Coverage from your previous insurance carrier / employer? **Application Section V.**
- If you qualify based on rejection of other coverage or a higher premium than ICHIA**, did you provide gross income and number of family members? **Application Section VIII.**
- Did you sign the Disclosure Authorization and Declaration? **Application Section IX.**
- Did you identify a premium payment cycle (Monthly, Quarterly, Monthly Bank Draft, Quarterly Bank Draft or Monthly Credit Card)? **Application Section XI.**
- Have you included the premium payment due according to the payment cycle chosen (monthly payment cycle requires an initial two months of premium)? **Application Section XI.**
- If you chose the Monthly or Quarterly Bank Draft premium payment cycle, did you complete and sign the Authorization Agreement for Automatic Withdrawal? Did you attach a voided check? **Application Section XI.**
- If you chose the Credit Card premium payment cycle, did you complete and sign the Authorization Agreement for Automatic Credit Card Withdrawal? **Application Section XI.**

Your application should be processed within 10 business days from the date of receipt if all necessary information is included.

APPLICATION FOR COVERAGE



INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION (ICHIA)

POLICY ADMINISTERED BY:
ACS Healthcare Solutions (ACS)

P.O. Box 33009
Indianapolis, IN 46203-0009
1-800-552-7921 OR 317-614-2133
www.ichia.org

Please don't cancel your current insurance until you have been notified you are approved by ICHIA.

Please type or print in black ink. All questions must be filled out with complete detail (attach a separate piece of paper if necessary). If you have questions while completing the application, log onto our **web site** at **www.ichia.org** or call **customer service** at **1-800-552-7921**.

FOR OFFICE USE ONLY

EFFECTIVE DATE
OF COVERAGE:

SECTION I: PLAN INFORMATION

Please choose one: I understand once eligibility is verified, the effective date of coverage will be the later of: 1) the date application is approved, 2) the day after your previous major medical coverage ends or 3) the following date as requested _____.
(Requested date must be a future date not exceeding 60 days.)

A	<input type="checkbox"/> PLAN 1	(\$500 DEDUCTIBLE and \$1,000 COINSURANCE = \$1,500 OUT-OF-POCKET MAXIMUM)
	<input type="checkbox"/> PLAN 2	(\$1,000 DEDUCTIBLE and \$2,000 COINSURANCE = \$3,000 OUT-OF-POCKET MAXIMUM)
	<input type="checkbox"/> PLAN 3	(\$1,500 DEDUCTIBLE and \$2,500 COINSURANCE = \$4,000 OUT-OF-POCKET MAXIMUM)
	<input type="checkbox"/> PLAN 4	(\$2,500 DEDUCTIBLE [CO-MINGLED PHARMACY AND MEDICAL] and \$2,500 COINSURANCE = \$5,000 OUT-OF-POCKET MAX)
	<input type="checkbox"/> PLAN 5	(\$5,000 DEDUCTIBLE [CO-MINGLED PHARMACY AND MEDICAL] and \$900 COINSURANCE = \$5,900 OUT-OF-POCKET MAX)
NOTE: YOU MUST HAVE PROOF OF MEDICARE D IN ORDER TO APPLY FOR THE PLANS BELOW WITHOUT RX		
	<input type="checkbox"/> PLAN 1 Rx	(SAME AS PLAN 1 ABOVE WITH MEDICARE PART D INSTEAD OF ICHIA'S PHARMACY COVERAGE)
	<input type="checkbox"/> PLAN 2 Rx	(SAME AS PLAN 2 ABOVE WITH MEDICARE PART D INSTEAD OF ICHIA'S PHARMACY COVERAGE)
	<input type="checkbox"/> PLAN 3 Rx	(SAME AS PLAN 3 ABOVE WITH MEDICARE PART D INSTEAD OF ICHIA'S PHARMACY COVERAGE)
<p>Please Note: In the future, you may only elect to change a Plan to one with a HIGHER deductible. This change will take effect on the following January 1st only and must be received by us not later than December 1st.</p>		

SECTION II: APPLICANT INFORMATION

E-MAIL ADDRESS (optional)

B LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER - - -
STREET ADDRESS (Mandatory)		SEX (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE: MONTH / DAY / YEAR / AGE
CITY	STATE	ZIP CODE	COUNTY OF RESIDENCE
HOME TELEPHONE ()	WORK TELEPHONE ()	CUSTODIAL PARENT / GUARDIAN IF APPLICANT IS A MINOR	SOCIAL SECURITY NUMBER - - -

SECTION III: DEPENDENT / SPOUSE INFORMATION

List dependents (including spouse) to be covered under this plan. Dependents must be (1) unmarried and under the age of 19, (2) unmarried, under the age of 24, or unmarried, under the age 25 AND a full-time student at an accredited high school, technical or vocational school, or college or university and is chiefly dependent upon you for support, OR (3) unmarried, incapable of self-sustaining employment by reason of mental retardation or mental or physical disability, and chiefly dependent upon you for support. Proof may be required.

C LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER - - -
RELATIONSHIP TO APPLICANT <input type="checkbox"/> Spouse <input type="checkbox"/> Child	FULL-TIME STUDENT <input type="checkbox"/> Yes <input type="checkbox"/> No	INCAPABLE OF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY <input type="checkbox"/> Yes <input type="checkbox"/> No	SEX (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female
BIRTHDATE: MONTH / DAY / YEAR / AGE			
D LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER - - -
RELATIONSHIP TO APPLICANT <input type="checkbox"/> Spouse <input type="checkbox"/> Child	FULL-TIME STUDENT <input type="checkbox"/> Yes <input type="checkbox"/> No	INCAPABLE OF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY <input type="checkbox"/> Yes <input type="checkbox"/> No	SEX (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female
BIRTHDATE: MONTH / DAY / YEAR / AGE			
E LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER - - -
RELATIONSHIP TO APPLICANT <input type="checkbox"/> Spouse <input type="checkbox"/> Child	FULL-TIME STUDENT <input type="checkbox"/> Yes <input type="checkbox"/> No	INCAPABLE OF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY <input type="checkbox"/> Yes <input type="checkbox"/> No	SEX (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female
BIRTHDATE: MONTH / DAY / YEAR / AGE			

SECTION IV: ELIGIBILITY INFORMATION

PLEASE CHECK AND INITIAL EACH ELIGIBILITY CATEGORY FOR WHICH YOU ARE APPLYING

F Each Eligibility Category **REQUIRES ONE** of the following Documentary Proofs of Residency:

- 1) **PROOF OF CURRENT RESIDENCY** in the state of Indiana, which may include one of the following documents; a receipt within 3 months prior to the date of the application for rent, mortgage payment, utility bill; a resident Indiana income tax return for the most recent 12 month tax period; a copy of your active Indiana driver's license **OR** a copy of your active Indiana personal identification card issued by the Indiana Bureau of Motor Vehicles; or
- 2) **PROOF OF 12 MONTH RESIDENCY** in the state of Indiana, which may include one of the following documents; a receipt 12 months prior to date of application **AND** another receipt within the last 3 months prior to the date of application for rent, mortgage payment, utility bill; a resident Indiana income tax return for the most recent 12 month tax period, a copy of your Indiana driver's license issued at least 12 months ago **OR** a copy of your Indiana personal identification card issued by the Indiana Bureau of Motor Vehicles dated 12 months or more prior to the date of application for ICHIA. Federally eligible individuals only need to submit current proof of residency.

I CERTIFY that I am eligible for coverage because:
 (Please check the eligibility category you are applying under)

F-1 **FEDERALLY ELIGIBLE**

I am federally eligible according to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 because I have had health care coverage for at least 18 months prior to the effective date of coverage with no lapse in coverage exceeding 63 days. My most recent coverage was under a group plan and I have exhausted my benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA), IF OFFERED. I am not eligible under another group health plan offered by my employer or as a dependent for coverage through my spouse, parent or guardian; my most recent coverage was not cancelled because I failed to pay my premiums, failed to pay my premiums in a timely manner or committed fraud; I am not eligible for Medicare or Medicaid; and I did not accept a conversion policy or a short-term limited duration policy after my group, COBRA or state continuation coverage ended.

Name of the organization that provided your last month of coverage: _____
(month/date/year)

The date you terminated from the organization that provided your last month of coverage: _____/_____/_____

Reason for termination of coverage: Failure to pay premiums For Fraudulent Reasons Other (Explain) _____

Did your former employer sponsor a health insurance plan for any of its employees? YES NO

Which of the following types of organizations was your former employer? Company Governmental Entity
 Church Other (Explain) _____

At the time you terminated employment with your former employer, did your former employer offer you an opportunity to continue your group insurance coverage (with you paying the premium) under COBRA or state continuation coverage? YES NO

REQUIRED DOCUMENTATION (Must Accompany This Application):

- 1) A copy of the **Certificate of Health Plan Coverage** provided by your previous insurance carrier / employer, a letter from the insurance carrier dated AFTER your coverage ended indicating your length of coverage, explanations of benefits (EOBs), other correspondence from a plan or issuer or paystubs that clearly establish 18 months of coverage with no lapse in coverage exceeding 63 days.
- 2) **Documentary PROOF OF CURRENT RESIDENCY** in the state of Indiana (See Section F for required documentation).

_____ **Initial Here**

F-2 **REJECTION FOR OTHER HEALTH COVERAGE**

I received notification of rejection from one health insurer for individual health insurance coverage substantially similar to the coverage offered by ICHIA.

Date your last health coverage ended: _____

If your health coverage ended within 90 days of the date of application, have you been offered a Conversion Policy? YES NO

REQUIRED DOCUMENTATION (Must Accompany This Application):

- 1) A copy of the letter of rejection from health insurer on company letterhead that is dated within 90 days of the date on the application and must be signed by an underwriter or appropriate staff person. It must include ICHIA applicant's name and show that they are uninsurable.
- 2) **Documentary PROOF OF 12 MONTH RESIDENCY** in the state of Indiana (See Section F for required documentation).

_____ **Initial Here**

F-3 **PREMIUM RATE HIGHER THAN ICHIA**

I am currently on an individual policy and am not eligible for any coverage that equals or exceeds the minimum requirements for Accident and Sickness policies in Indiana. I received a recent premium notice for health insurance coverage exceeding the premium rate for coverage by ICHIA.

REQUIRED DOCUMENTATION (Must Accompany This Application):

- 1) **A copy of the premium notice and deductible for the policy** must accompany your application.
- 2) **Documentary PROOF OF 12 MONTH RESIDENCY** in the state of Indiana (See Section F for required documentation).

_____ **Initial Here**

SECTION V: OTHER HEALTH CARE COVERAGE

G YES NO Do you or any person named on this application have any other **medical or hospital insurance in effect or for which you are eligible?**

If **YES**: Name of person(s): _____

Insurance Company Name: _____

Insurance Company Phone: _____

Are you eligible for **MEDICARE Part A** Yes No If yes, Effective Date of Part A _____

Are you eligible for **MEDICARE Part B** Yes No If yes, Effective Date of Part B _____

Are you eligible for **MEDICARE Part D** Yes No If yes, Effective Date of Part D _____

YOU MUST SEND IN A COPY OF YOUR MEDICARE CARD WITH THIS APPLICATION.

TYPE OF COVERAGE::

Is your current coverage **GROUP**? YES NO

(month/date/year)

The date you terminated or will be terminated from the organization that is providing your group coverage _____ / _____ / _____

Are you currently covered by **COBRA** or state continuation coverage? YES NO

If **YES**, and if you are approved for coverage with **ICHIA**, how many months will you have been on **COBRA** or state continuation coverage by the time you start coverage with **ICHIA**? _____

Is your current coverage **INDIVIDUAL**? YES NO

If **YES**, check the box that best describes your coverage:

- Comprehensive Major Medical (CMM) Limited benefit (e.g., "hospital-only" coverage or "cancer-only" coverage, etc.)
- Union plan Professional or trade association plan Student health plan
- Another state health benefits risk pool (a plan like **ICHIA**)
- Medicare (disabled) under age 65 Medicare over age 65
- Other (Explain): _____

Is it your intent to replace your current coverage with **ICHIA** coverage? YES NO

If **YES**, please explain the reason for replacement: _____

If **NO**: Does your current employer offer health coverage to any of its employees? YES NO

If **YES**, has your employer offered you an opportunity to participate in the employer-sponsored health plan?

YES NO

If **YES**, why aren't you participating in the employer-sponsored plan?

I have waived my employer-sponsored coverage

I have been directed or encouraged to apply for _____
(Please explain under "Other" above.)

Based on Indiana Law, effective July 1, 2003 all **ICHIA** applicants must apply for **Medicaid** within 60 days prior to applying to **ICHIA**. You must provide proof of **Medicaid Application**. (This does not apply to federally eligible individuals.) If it is determined you are eligible for **Medicaid** after you are approved for **ICHIA**, your **ICHIA** coverage will be terminated the date you were **eligible** for coverage under **Medicaid**. Any premium paid for periods subsequent to the Effective Date of coverage under **Medicaid** will be returned to you, less any unrecoverable claim payments, including drugs, made for services incurred during enrollment in **ICHIA**. No claims will be paid for any period which premium has not been received. Have you enclosed the proof of **Medicaid Application**? _____ (check here)

SECTION VI: PREMIUM PROVISION

H Will any **PART** or **ALL** of the premium used to purchase this coverage be provided by:

A church / church affiliated group YES NO

A division of government, either county, city, state, federal or other? YES NO

A government agency, such as **Medicaid**, **Medicare**, public health department or other programs such as indigent programs? YES NO

A public or private foundation? YES NO

A health care provider? YES NO

An employer of the individual? YES NO

A person other than the individual's parent, adult child or guardian? YES NO

Other _____ (please explain) YES NO

If you answered "YES" to any question above, please list the following:

Name of organization: _____

Address of organization: _____

Phone number of organization: _____

SECTION X: RESEARCH AUTHORIZATION

Under limited circumstances, ICHIA may use or share some medical information of its participants for the purpose of research and research-related studies. The information used or shared will not individually identify any participant and will meet all privacy law requirements in effect at the time.

L	SIGNATURE OF APPLICANT	DATE OF APPLICATION (MONTH / DAY / YEAR) / /

M	SIGNATURE OF CUSTODIAL PARENT OR GUARDIAN (if applicant is under age 18)	DATE: (MONTH / DAY / YEAR) / /

SECTION XI: PREMIUM PAYMENT

N PLEASE CHOOSE ONE OF THE PREMIUM PAYMENT OPTIONS BELOW: _

MONTHLY - 2 MONTHS PREMIUM **MUST BE SENT** WITH APPLICATION.

QUARTERLY - 3 MONTHS PREMIUM **MUST BE SENT** WITH APPLICATION.

PAYMENT METHOD SELECTION

I have enclosed a CHECK in the amount of \$ _____.

I will continue to pay by CHECK the premium payment option I have chosen above.
- OR -

I would like my premium payment withdrawn automatically every month or every quarter from my checking account. I have completed the Authorization Agreement for Automatic EFT Withdrawal.
- OR -

I would like future payments withdrawn from my credit card. I UNDERSTAND THAT MY CREDIT CARD WILL BE CHARGED MONTHLY EVERY MONTH THEREAFTER UNTIL SUCH TIME AS MY POLICY IS TERMINATED OR I ELECT TO CHANGE MY PAYMENT METHOD.

Please bill my CREDIT CARD based on the option I have chosen above. I have completed the Authorization Agreement for Automatic Credit Card Withdrawal.

I will continue to pay by CREDIT CARD. I UNDERSTAND THAT AFTER THE INITIAL PREMIUM PAYMENT IS DRAWN ON MY CREDIT CARD, IF I CHOOSE TO CONTINUE BY CREDIT CARD, MY CREDIT CARD WILL BE CHARGED MONTHLY EVERY MONTH THEREAFTER UNTIL SUCH TIME AS MY POLICY IS TERMINATED OR I ELECT TO CHANGE MY PAYMENT METHOD.
- OR -

I would like my premium payment withdrawn automatically every month or every quarter from my checking account. I have completed the Authorization Agreement for Automatic EFT Withdrawal.
- OR -

I will make premium payments by check based on the premium payment option I have chosen above.

IF YOU ELECT TO PAY YOUR PREMIUM BY CHECK AND NO PREMIUM IS RECEIVED WITH THE APPLICATION, YOUR APPLICATION WILL BE REJECTED.

O USE THE PREMIUM RATE TABLE TO DETERMINE YOUR PREMIUM PAYMENT:

RATE AREA YOUR RESIDENCE IS IN:	FOR OFFICE USE ONLY		
PREMIUM AMOUNT ENCLOSED	\$		
→	<table border="1" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">PREMIUM PAYMENT</td> <td style="width: 50%; text-align: center;">CHECK NUMBER</td> </tr> </table>	PREMIUM PAYMENT	CHECK NUMBER
PREMIUM PAYMENT	CHECK NUMBER		

AUTHORIZATION AGREEMENT FOR AUTOMATIC EFT WITHDRAWAL OF INSURANCE PREMIUM

The Indiana Comprehensive Health Insurance Association (ICHIA) offers a convenient payment option for enrollees who are on a **monthly or quarterly premium payment cycle**. Your premiums can be automatically withdrawn from your checking account on a monthly / quarterly basis.

The withdrawal is done on the 1st Friday of each month in the bank's nightly cycle. (If the 1st Friday of the month falls on the 1st, 2nd or 3rd day of the month, the withdrawal takes place on the 2nd Friday of the month).

To have your premium payment automatically withdrawn from your checking account monthly or quarterly:

1. Complete the **Authorization Agreement** below.
2. Verify your **Account Number** and **Routing Number** with your financial institution (frequently, the account number listed on your check includes digits that are not actually part of the account number).
3. Send a copy of a **Voided Check** with your application.

(detach here)

AUTHORIZATION AGREEMENT FOR AUTOMATIC EFT WITHDRAWAL (CHOOSE MONTHLY OR QUARTERLY EFT ONLY)



If you are already an ICHIA member, please state your Member Identification No. _____

I hereby request and authorize the Financial Institution named below to pay and charge to my account checks / drafts drawn on my account by and payable to the order of Indiana Comprehensive Health Insurance Association (ICHIA) provided there are sufficient collected funds in my account to pay such checks / drafts upon presentation. I agree that your rights in respect to each such check / draft shall be the same as if it were a check / draft drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such check / draft.

I further agree that if any such check / draft is not honored, whether with or without cause and whether intentionally or inadvertently, you shall have no liability whatsoever even though such action results in forfeiture of medical insurance coverage. This authorization is to remain in effect until you receive 15 days written notice from me of its revocation.

BANKING INFORMATION

NAME OF INSURED (APPLICANT)		NAME OF JOINT ACCOUNT HOLDER	
NAME OF FINANCIAL INSTITUTION		TYPE OF ACCOUNT	
FINANCIAL INSTITUTION ADDRESS		<input type="checkbox"/> Checking <input type="checkbox"/> Savings	
		<input type="checkbox"/> Monthly EFT <input type="checkbox"/> Quarterly EFT	
		ACCOUNT NUMBER	
CITY	STATE	ZIP CODE	9 DIGIT ROUTING NUMBER

SIGNATURE OF ACCOUNT HOLDER(S)

NAME OF ACCOUNT HOLDER (please print)		NAME OF JOINT ACCOUNT HOLDER (please print)	
SIGNATURE		SIGNATURE	
DATE (mm / dd / yy) / /		DATE (mm / dd / yy) / /	

TO FINANCIAL INSTITUTION: In consideration of your honoring pre-authorized checks / drafts drawn against depositors of your financial institution for the payment of amounts to the Indiana Comprehensive Health Insurance Association (ICHIA), we agree that no liability or responsibility shall attach to your financial institution as a result of honoring or not honoring such checks / drafts, and we further agree to hold you harmless from and reimburse you for any loss resulting as a consequence of your actions taken pursuant to your agreement to honor such checks / drafts. We shall defend any action brought against you by any of your depositors or any other person because of your compliance with the pre-authorized check / draft plan.

USE FOR EFT WITHDRAWAL ONLY

AUTHORIZATION AGREEMENT FOR CREDIT CARD WITHDRAWAL OF INSURANCE PREMIUM

The Indiana Comprehensive Health Insurance Association (ICHIA) offers a convenient payment option for members who are on a **monthly premium payment cycle**. Your premiums can be automatically withdrawn from your credit card account on a monthly basis.

The withdrawal from your credit card is done on the 15th of the month for the next month's coverage period with the exception of your initial withdrawal which **will be for 2 months**. If the 15th falls on a weekend or holiday, the withdrawal will be done on the next business day.

To have your premium payment automatically withdrawn from your credit card account monthly or quarterly:

1. Complete the **Credit Card Withdrawal Authorization Agreement** below.
2. Verify your **Account Number**
3. **NOTE:** This form must be 100% filled out in order to do the withdrawal. If any part is not completed, the **entire form will have to be done over.**

(detach here)

CREDIT CARD WITHDRAWAL AUTHORIZATION AGREEMENT



If you are already an ICHIA member, please state your Member Identification No. _____

I hereby request and authorize Indiana Comprehensive Health Insurance Association (ICHIA) to automatically withdraw from my credit card account the amount of the monthly premium bill and applicable service and transaction fees due by me. I agree that your rights in respect to each such credit card withdrawal shall be the same as if it were a charge signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such credit card withdrawal. **NOTE: I must give 60 days written notice to stop or change this authorization. ICHIA will not refund any transaction fees or interest fees. ICHIA will not be held liable for any interest charges incurred by my credit card company unless an error is a direct result of ICHIA.**

I further agree that if any such credit card withdrawal is not honored, whether with or without cause and whether intentionally or inadvertently, you shall have no liability whatsoever even though such action results in forfeiture of medical insurance coverage. This authorization is to remain in effect until you receive **60 days written notice** from me of its revocation.

NOTE TO DEBIT CARD HOLDERS: You may wish to use the EFT option to avoid the Visa / MasterCard transaction fees.

CREDIT CARD INFORMATION				ALL BLOCKS MUST BE 100% FILLED IN OR YOU WILL HAVE TO FILL OUT ANOTHER FORM IN ITS ENTIRETY	
NAME OF CARD HOLDER		NAME OF INSURED (IF DIFFERENT THAN CARD HOLDER)S		TYPE OF CREDIT CARD <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	
CARD HOLDER ADDRESS		CREDIT CARD NUMBER		CVV2 Number (see below)	
		<small>(You must include the CVV2 number. This is a 3-digit number at the end of your credit card number located in the printed version of the number on the back of the card.)</small>			
CITY		STATE		ZIP CODE	
		EXPIRATION DATE _____ / _____		<input type="checkbox"/> One Time Only Deduction <input type="checkbox"/> Continuous Deduction	
TOTAL CREDIT CARD CHARGE TO BE WITHDRAWN:		How to Calculate Your Credit Card Charge: PLEASE SEE THE BACK OF THIS FORM FOR INSTRUCTIONS			
This withdrawal will be taken on the 15th of each month for the next coverage period.		1) \$ _____ Monthly Premium Amount 2) \$ _____ 2.17% Visa / MasterCard Fee 3) \$ _____ \$3.00 Transaction Fee (DO NOT double this fee with your initial premium) TOTAL \$ _____			

* This premium is subject to change based on the member's birthday due to the rate differentials by age and periodic ICHIA rate changes.

SIGNATURE OF ACCOUNT HOLDER(S)

NAME OF ACCOUNT HOLDER (please print)		NAME OF JOINT ACCOUNT HOLDER (please print)	
SIGNATURE		SIGNATURE	
DATE (mm / dd / yy) / /		DATE (mm / dd / yy) / /	

TO FINANCIAL INSTITUTION: In consideration of your honoring pre-authorized credit card withdrawals against card owners of your financial institution for the payment of amounts to the Indiana Comprehensive Health Insurance Association (ICHIA), we agree that no liability or responsibility shall attach to your financial institution as a result of honoring or not honoring such credit card withdrawals, and we further agree to hold you harmless from and reimburse you for any loss resulting as a consequence of your actions taken pursuant to your agreement to honor such credit card withdrawals. We shall defend any action brought against you by any of your credit card owners or any other person because of your compliance with the pre-authorized credit card withdrawal plan.

INSTRUCTIONS ON HOW TO CALCULATE YOUR CREDIT CARD CHARGE

If you are filling out this form at the same time you are filling out your application, please use the following steps.

Multiply your monthly fee x 2 and enter it on line 1.

Multiply line 1 times 2.17% which is the Visa / MasterCard Fee and enter this dollar amount on line 2.

Line 3 will **always** be \$3.00 (it will not increase because you are sending 2 month's premium).

Add lines 1, 2 and 3 together and this will be the TOTAL Premium you need to send in with your application or if you prefer, you can request us to withdraw this amount from your credit card.

If you are filling out this form at a later date because you are changing the way you are paying your monthly premium:

Enter your monthly fee on line 1.

Multiply line 1 times 2.17% which is the Visa / MasterCard Fee and enter this dollar amount on line 2.

Line 3 shows the Transaction Fee of \$3.00.

Add lines 1, 2 and 3 together and this will be the TOTAL Premium that will be withdrawn from your credit card each month.

**YOU MUST SUBMIT A NEW CREDIT CARD
AUTHORIZATION FORM
WHEN YOUR CURRENT CREDIT CARD EXPIRES**

**IF YOU DO NOT SEND IN A NEW ONE,
YOU WILL BE AUTOMATICALLY
SWITCHED TO MONTHLY PAPER BILL**

SECTION IV: ELIGIBILITY REQUIREMENTS

FEDERALLY ELIGIBLE DEFINITION: According to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 you have had health care coverage for at least 18 months prior to the effective date of coverage with no lapse in coverage of at least 63 days. Your most recent coverage was under a group plan and you have exhausted your benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA), IF OFFERED. You are not eligible under another group health plan offered by your employer or as a dependent for coverage through your spouse, parent or guardian; your most recent coverage was not cancelled because you failed to pay your premiums, failed to pay your premiums in a timely manner or committed fraud; You are not eligible for Medicare or Medicaid; and you did not accept a conversion policy or a short-term limited duration policy after your group, COBRA or state continuation coverage ended.

F POLICYHOLDER MUST BE A RESIDENT OF INDIANA. "Resident" refers to a person who has, for at least 12 months immediately preceding this application for this policy, resided continuously in the state of Indiana in a place of permanent habitation. If you are a spouse / dependent who is federally eligible, this does not apply.

PROOF OF RESIDENCY IS REQUIRED. At least **one** of the following documents or other evidence of residency **must accompany your application**; rent receipts, mortgage payment receipts, a resident Indiana income tax return for the most recent 12 month tax period, utility bills in the past three months; a copy of policyholder's Indiana driver's license; **OR** a copy of policyholder's Indiana personal identification card issued by the Indiana Bureau of Motor Vehicles.

I have been a resident of the state of Indiana continuously since _____ (month / day / year).
 _____ Initial Here

F-1 Spouse / dependent(s) eligible for Medicaid are not eligible for this policy.

F-2 Spouse / dependent(s) who are eligible for coverage under any other group health plan or who have other health insurance, are not eligible for this policy.

- F-3** Dependent children (if to be covered) can only be covered as long as one of the following requirements are met:
- Unmarried and under the age of 19, or
 - Unmarried and under the age of 25 and is a full-time student in any accredited high school, trade school, college or university and is chiefly dependent on you for support, or
 - Unmarried and incapable of self-sustaining employment by the reason of mental retardation or mental or physical disability; and is chiefly dependent on you for support.

SECTION V: PRE-EXISTING CONDITIONS PROVISION

G Benefits under any ICHIA policy (including spouse / dependent) will not be payable for a pre-existing condition (injury or sickness) for the first three months following the effective date of coverage if medical advice or treatment for the pre-existing injury or sickness was recommended or received within a period of three months before the effective date of coverage.

WAIVER BENEFIT is the same for spouse and dependents as for the policyholder. Spouses / dependents who are federally eligible individuals cannot be denied coverage for a condition, based upon the fact that the condition was present before the first day of coverage, regardless of whether any medical advice, diagnosis, care or treatment was recommended or received before that day.

SECTION VI: PREMIUM PAYMENT

H If the policyholder is paying monthly, please include one month's premium with your application.

If the policy holder is paying quarterly, please include three month's premium with your application.

I USE THE PREMIUM RATE TABLE TO DETERMINE YOUR PREMIUM PAYMENT:

RATE AREA YOUR RESIDENCE IS IN:	FOR OFFICE USE ONLY																								
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SECTION VI: OTHER HEALTH CARE COVERAGE

H YES NO Is any spouse / dependent named on this application enrolled in **Medicare**?

If **YES**, name of person(s): _____

Identification Number(s): _____

Are you eligible for **MEDICARE Part A** **Yes** **No** _____

Are you eligible for **MEDICARE Part B** **Yes** **No** _____

Are you eligible for Medicare **Part D** **Yes** **No** _____

I YES NO Is any spouse / dependent named on this application enrolled in **Medicaid**?

If **YES**, name of person(s): _____

Identification Number(s): _____

Effective Date(s): _____

J YES NO Do you or any spouse / dependent named on this application have any other **medical or hospital insurance**?

If **YES**, name of person(s): _____

Insurance Company Name: _____

Insurance Company Phone: _____

Is it a Group Plan? YES NO Is it a Group Plan? YES NO

Is it your intent to replace it with this coverage? YES NO If **YES**, please explain reason for replacement.

Reason(s) must meet requirements stated in Part IV.

K YES NO Does employer offer health insurance benefits for the policyholder, spouse or dependent?

If yes, please list the individual(s) below and provide employer's name and address:

APPLICANT / PARENT / GUARDIAN	SPOUSE / DEPENDENT
Employer Name _____	Employer Name _____
Street Address _____	Street Address _____
City / State / Zip _____	City / State / Zip _____
Telephone _____	Telephone _____

SECTION VII: DISCLOSURE AUTHORIZATION AND DECLARATION

I certify that the foregoing statements are true and accurate to the best of my knowledge and belief. I understand that no coverage will be effective until the full initial premium is paid and this application has been approved. I further certify that in the event I obtain other similar health coverage or change my residency, I will notify ICHIA of the other coverage or of my new address.

Signature of Policyholder	Date	Signature of Spouse / Non-Minor Dependent	Date
Signature of Policyholder	Date	Signature of Spouse / Non-Minor Dependent	Date
Signature of Policyholder	Date	Signature of Spouse / Non-Minor Dependent	Date



INDIANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

P.O. Box 33009
Indianapolis, IN 46203-0009
1.800.552.7921
317.614.2133
www.ichia.org

PROOF OF MEDICAID APPLICATION

Please Note: 1. You must apply for Medicaid 60 days PRIOR to applying with ICHIA. **This form does not apply to federally eligible individuals.**
2. You must apply for the Healthy Indiana Plan (HIP) PRIOR to applying with ICHIA.

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBER: _____

SOCIAL SECURITY NUMBER: _____

FOR MEDICAID OFFICE ONLY

This will hereby verify that _____ (applicant) has made application with the Indiana Medicaid Program through the Medicaid office located at _____ on the date of _____.

AUTHORIZED MEDICAID REPRESENTATIVE NAME (PRINT): _____

AUTHORIZED MEDICAID REPRESENTATIVE SIGNATURE: _____

PHONE NUMBER OF MEDICAID REPRESENTATIVE: _____

SIGNATURE/AUTHORIZATION

I, _____ (ICHIA applicant or member), by signing this form, am verifying to the Indiana Comprehensive Health Insurance Association (ICHIA) that I have made application to the Indiana Medicaid Program on _____ (date) and will advise ICHIA immediately upon receipt of my acceptance or rejection notice to the Indiana Medicaid Program. Furthermore, I understand that by signing this form I am confirming my authorization that (if necessary) the health plan may contact Indiana Medicaid for the purpose of verifying my eligibility status with the Indiana Medicaid Program.

PRINTED NAME: _____

SIGNATURE: _____

IF A MINOR, PRINTED NAME OF LEGAL GUARDIAN: _____

IF A MINOR, SIGNATURE OF LEGAL GUARDIAN: _____

SIGNATURE DATE: _____

FOR OFFICE USE ONLY:

ICHIA POLICY NUMBER: _____

MEDICAID CASE / RID NUMBER: _____
(If applicable)