Traditional Plan Application
and
Federal High-Risk Pool Application

***Applications must be submitted within 30 days after losing prior coverage, except for the federal MAC Plan. For MCHA to determine whether or not credit can be given toward the preexisting exclusion period, you must submit your application before the 30-day time period ends. You can follow up with the documents necessary to determine eligibility for the Plan. Citizenship for the federal MAC Plan can be documented with a birth certificate or other acceptable documentation. Please visit www.mthealth.org, or call 1-800-447-7828, Extension 2128, if you have questions about the required documentation.**

MCHA Plan	Deductible	Coinsurance	Maximum Annual Liability
Option I – Indemnity Plan 1000	$1,000	80/20	$5,000
Option II – PPO 1000	$1,000	80/20 – 60/40	$5,000
Option III – PPO 2500	$2,500	80/20 – 60/40	$6,750
Option IV – PPO 5000	$5,000	80/20 – 60/40	$9,500
Option V – PPO 7500	$7,500	80/20 – 60/40	$12,250
Option VI – PPO 10000	$10,000	80/20 – 60/40	$15,000
Option VII – Medicare Carveout PPO	$1,000	80/20 – 60/40	$5,000
Premium Assistance PPO 1000	$1,000	80/20 – 60/40	$5,000
Premium Assistance Medicare Carveout PPO 1000	$1,000	80/20 – 60/40	$5,000
Federal High-Risk Pool			
MAC Plan (Federal High-Risk Plan)	$2,500	70/30 – 50/50	$5,950

Enrollment in the federal MAC Plan is limited and on a first-come basis. The federal MAC plan is funded by insured's premium and federal funding. If the federal high risk pool program is terminated for any reason before January 1, 2014, insureds may move to an MCHA traditional plan of the insured's choice. The insured will need to pay the full MCHA premium for that coverage.

Administered by
Blue Cross and Blue Shield of Montana
560 North Park Avenue
P.O. Box 4309
Helena, MT 59604-4309
1-800-447-7828, Extension 2128

APPLICATION FOR MCHA COVERAGE

Incomplete information may delay the processing of your application.

PLEASE TYPE OR PRINT IN BLACK INK

Applicant Information

Social Security Number (SSN) or immigration document number (required for MAC Plan - see checklist)		**Date of Birth** (mo / day / yr) / /	❑ **Male** ❑ **Female**
	Birthplace (Required for MAC Plan)	**City**	**State**
Last Name	**First Name**		**Middle Initial**

Applicant Residence Address	**City**	**State**	**ZIP Code**	**County**
Applicant Mailing Address (if different from above)	**City**	**State**	**ZIP Code**	**County**
Applicant Billing Address (if different from mailing address)	**City**	**State**	**ZIP Code**	**Telephone Number**

Traditional Plan Options

Select your option for coverage:

❑ **Option I – Indemnity Plan 1000** ❑ **Option IV – PPO 5000** ❑ **Option VII – Medicare Carveout PPO 1000**

❑ **Option II – PPO 1000** ❑ **Option V – PPO 7500** ❑ **Federal High-Risk Pool – MAC Plan**

❑ **Option III – PPO 2500** ❑ **Option VI – PPO 10000** (Options I – VII may have a 12-month preexisting condition exclusion.)

For the Medicare Carveout Premium Assistance Plan PPO 1000 and the Premium Assistance Plan PPO 1000, an additional form is required, and will serve as your option selection. (There may be a 4-month preexisting condition exclusion.)

Effective Date Requested ____________________________

Subject to MCHA approval. Cannot be before receipt date by MCHA.

Eligibility Questionnaire

1. Are you a resident of Montana? ❑ Yes ❑ No If yes, for how long? Years ________ Months ________
2. Are you a U.S. citizen or legally present? (Documentation required for MAC Plan only.) ❑ Yes ❑ No
3. How long have you been uninsured? ________________ What was your last date of coverage? ________________
4. Please attach two items as proof of residency showing your physical Montana address (e.g., driver's license, recent receipts, state income tax return, house payment records, employment records). You must be a Montana resident for at least 30 days for all options (except the MAC Plan).
5. Are you covered by or eligible for Medicare? If yes, please attach a copy of your HIB or Medicare card. ❑ Yes ❑ No
6. Are you enrolled for Medicaid coverage? ❑ Yes ❑ No
7. Are you currently covered under any other comprehensive health insurance? If yes, please provide the carrier name, carrier telephone number, the cancellation date, and reason for the cancellation in the space below. ❑ Yes ❑ No

   Is this coverage a governmental plan? ❑ Yes ❑ No Or a self-funded group plan? ❑ Yes ❑ No

   Full Name and Telephone Number of Insurance Company or Carrier Name ________________ Identification or Policy Number ________________

   Cancellation Date ________________ Reason(s) for Cancellation ________________
8. If you are currently covered under other health insurance, are you applying for MCHA coverage because your premium rates are higher than the average premium rate used to calculate MCHA premiums (provided in MCA 33-22-1501(7)(B))? Submit a current summary of benefits and current rate for individual coverage. (Not required for MAC plan.) ❑ Yes ❑ No
9. Are you currently employed? If yes, please provide your employer's name and address. ❑ Yes ❑ No

   ____

   Does your employer sponsor a health benefit plan? Does your spouse's employer offer a health benefit plan? ❑ Yes ❑ No

   If yes to either question, were you denied coverage or provided coverage with a restrictive rider by reason of health? ❑ Yes ❑ No

   Please explain the circumstances that resulted in your rejection or the issuance of a restrictive rider. ________________

   Please provide the name of your employer's or your spouse's employer's carrier and the group policy number. ________________

   If you are employed and/or will be leaving employer group coverage, you may be a "federally defined eligible individual" and you should apply for coverage through the MCHA Portability Plan. Federally defined eligible individual means an individual for whom, as of the date of the application, has 18 months of other health insurance coverage which would qualify as "creditable coverage," who is not eligible for coverage under a group health plan, Social Security (Medicare), or Medicaid and who, if offered the option of continuation coverage under COBRA (or a state plan), has elected and exhausted that option.
10. Have you had continuous coverage for any time immediately preceding this application with a cancellation date within 30 days prior to the date of submitting this application? (Not required for MAC plan.) ❑ Yes ❑ No

    If yes, provide your original effective date of that coverage and attach a termination letter showing your cancellation date from your previous insurance coverage. If cancellation is dependent on obtaining MCHA coverage, submit a copy of the termination letter after coverage ends. Credit **may be** given toward the satisfaction of the preexisting condition limitation. ________________

    Creditable coverage is coverage that you had under any combination of the following plans, programs, and coverages: a group health plan, health insurance coverage, Medicare, TRICARE, Medicaid, Federal Employee Health Benefits Program (FEHBP), MCHA, a medical care program of the Indian Health Service or of a tribal organization, a high-risk pool in any state, a public health plan, and a health benefit plan under Section 5(e) of the Peace Corps Act.

Applicant Name:

11. **Please attach two (2) rejections (one [1] for the MAC plan) from within the last six months, or if you have any of the medical conditions listed below, please circle the condition and attach proof of the condition (e.g., claim with stated diagnosis).** If you are under age 19, please attach proof of one of the medical conditions listed below; if you have a serious medical condition not listed below, you may also be eligible for MCHA coverage based upon proof of that condition.

Medical Conditions

Acquired Immune Deficiency Syndrome (AIDS)
Alcoholism within the past 5 years
Alzheimer's Disease
Amyloidosis
Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
Anorexia
Aortic Aneurysm
Aplastic Anemia
Ascites
Autism
Banti's Disease
Berger's Disease
Bulimia within the past 5 years
Cardiac Asthma
Cardiomegaly
Cardiomyopathy
Cerebral Palsy
Charcot-Marie-Tooth
Chemical Dependency within the past 5 years
Chronic Pancreatitis
Chronic Renal Failure
Cirrhosis of the Liver
Congestive Heart Failure
COPD/Emphysema
Coronary Artery Disease
- By-Pass Surgery
- Angioplasty
- Myocardial Infarction

Crohn's Disease
Cystemegalorisus
Cystic Fibrosis
Diabetes Type I
Diabetes Type II
Down's Syndrome
Fanconi's Syndrome
Hansen's Disease (Leprosy)
Heart Valve Replacement (planned or history of)
Hemochromotosis
Hemophilia (A, B, or C)
Hepatitis C
History of Major Organ Transplant
HIV Positive
Huntington's Chorea
Hydrocephalus
Hypogammaglobulinemia
Leukemia (within 12 years)
Lupus Erythematosus Systemic
Malignant Tumor (list specific tumor)
Metastatic Cancer (within 12 years)
Morbid Obesity
Multiple Sclerosis
Muscular Dystrophy
Myasthenia Gravis
Neurofibromatosis
Osteogenesis Imperfecta
Pacemaker
Peutz-Jeghers Syndrome
Polycystic Kidney Disease
Primary Pulmonary Hypertension
Psychotic Disorders
Rheumatoid Arthritis
Sarcoidosis
Stroke
Tabes Dorsalis (Locomotor Ataxia)
Tetralogy of Fallot
TIAs (Transient Ischemic Attack)
Tuberculosis
Ulcerative Colitis
Von Willebrand's Disease
Wegener's Granulomatosis
Wilson's Disease

Conditions of Enrollment

I certify that my answers and statements are true and complete to the best of my knowledge. I certify that, within the last six months, a) I have been rejected or offered a restrictive rider for other health insurance coverage by two insurers, societies, or health service corporations due to reasons of health; or b) I currently have a policy with such restrictive rider and have been rejected two times for other coverage in the past six months; or c) I have a medical condition listed above.

If under the age of 19, I certify that my answers and statements are true and complete to the best of my knowledge, and that I have a medical condition listed above, or other serious medical condition.

For the federal MAC plan, I certify that I have not had comprehensive health coverage for the past six months.

I certify that I am not eligible for any other individual or group comprehensive health insurance coverage (not applicable to the MAC Plan). I additionally certify that neither my employer nor my spouse's employer is paying my MCHA health insurance premiums and that no employer will be reimbursing me for premiums that I pay to MCHA.

I understand that an intentional material misrepresentation or fraudulent misstatement on this application may result in loss of coverage. I understand that a person who submits an application or files a claim with the intent to defraud or helps commit a fraud against an insurer or health plan may be guilty of a crime under Montana Code 33-1, Part 12. **I enclose payment for one month's premium.**

For the MAC Plan, I understand that if I cease to meet the eligibility requirements for this plan, e.g., obtain other group coverage or am no longer a Montana resident, I am responsible to notify the lead carrier of the change and my MCHA coverage will end.

For all other plans, I understand that if I cease to meet the eligibility requirements for this plan, e.g., obtain or become eligible for other group coverage or am no longer a Montana resident, I am responsible to notify the lead carrier of the change and my MCHA coverage will end.

I certify that I have read the questions on page 3 that are designated "For Producer's Use Only" and I understand and agree to these questions.

Enrollment in the federal MAC plan is limited and on a first-come basis. The federal MAC plan is funded by the federal government. I understand that after the funding is exhausted, I may have the option to move to an MCHA traditional plan of my choice and I will be required to pay the regular MCHA premium.

Signature of Applicant
DO NOT PRINT

____

Signature Date
mo / day / yr

_____ / _____ / _____

Applicant Name:

PLEASE TYPE OR PRINT IN BLACK INK

Electronic Funds Transfer (EFT) Authorization

IMPORTANT

This electronic funds transfer (EFT) authorization section needs to be completed only if this is the payment method you have selected.

To ____, Montana.

(Name and City of Your Bank)

You are hereby authorized to honor Electronic Funds Transfer (EFT) drawn by Montana Comprehensive Health Association on my account in payment of Montana Comprehensive Health Association dues at the prevailing rate. This authorization is to remain in force until revoked by me in writing through the Office of Montana Comprehensive Health Association, Helena, Montana.

Date (mo / day / yr)	**Subscriber ID**
/ /	
Type of Account	**Account Number**
❑ Checking Account ❑ Savings Account	
PRINT Account Owner's Name	**Account Owner's Signature DO NOT PRINT**

*** * * * * * * * ATTACH A DEPOSIT SLIP OR A VOIDED CHECK * * * * * * * ***

Montana Comprehensive Health Association agrees to pay to any bank or banker all sums of money, which said bank or banker shall become legally obligated to pay because of any deduction of money for Montana Comprehensive Health Association as herein authorized by the bank customer whose signature appears above.

Producer's Use Only

1. Have you advised the Applicant to read, complete, and sign this Application Form to the best of his or her ability? ❑ Yes ❑ No
2. Have you advised the Applicant that coverage will not commence until he or she is notified that his or her Application has been received and has been accepted by the MCHA? ❑ Yes ❑ No
3. Have you advised the Applicant that if his or her Application contains any intentional material misrepresentation or fraudulent misstatement, coverage may be subject to rejection or termination? ❑ Yes ❑ No
4. Have you explained the preexisting condition limitation to the Applicant? (Does not apply to the federal MAC Plan and children under 19) ❑ Yes ❑ No
5. Do you certify that neither you nor, to your knowledge, anyone else has referred this Applicant to the MCHA Plan in order to separate the Applicant from a group health insurance contract obtained with the Applicant's employment? ❑ Yes ❑ No

Name	**Address**	**City**	**State**	**ZIP Code**

Disability Insurance State License Number	**Tax ID Number**	**Telephone Number**

Signature	**Date**	**BCBSMT Agent Number** (if applicable)

Lead Carrier Use Only

Group No. ____________ **Effective Date** ____________ **Package Number** ____________

Approved **Date** **Rejected** **Date**

Administered by
Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, MT 59604-4309
1-800-447-7828, Extension 2128