



PORTABILITY PLANS APPLICATION

*Applications must be submitted within 63 days after the end of your group or COBRA coverage. It is very important that you submit your application before the 63-day time period is over. You can follow up with the necessary documents to determine your eligibility for the Plan.

Plan	Deductible	Coinsurance	Maximum Annual Liability
Option I – Indemnity Plan 1000	\$1,000	70/30	\$3,000
Option II – PPO 1000	\$1,000	70/30 – 50/50	\$4,000
Option III – PPO 2500	\$2,500	70/30 – 50/50	\$5,750
Option IV – PPO 5000	\$5,000	70/30 – 50/50	\$8,500
Option V – PPO 7500	\$7,500	70/30 – 50/50	\$11,250
Option VI – PPO 10000	\$10,000	70/30 – 50/50	\$14,500

Administered by
Blue Cross and Blue Shield of Montana
560 North Park Avenue
P.O. Box 4309
Helena, MT 59604-4309

APPLICATION FOR MCHA PORTABILITY COVERAGE
PLEASE TYPE OR PRINT IN BLACK INK

Applicant Information	Social Security Number (SSN) _____ <small>Your SSN may be used in your subscriber identification number.</small>		Date of Birth mo / day / yr / /		<input type="checkbox"/> Male <input type="checkbox"/> Female	
	Last Name		First Name		Middle Initial	
	Applicant Residence Address		City	State	ZIP Code	County
	Applicant Billing Address (if different from above)		City	State	ZIP Code	Telephone Number

Portability Plan Options	Select your option for coverage:					
	<input type="checkbox"/> Option I – Indemnity Plan 1000		<input type="checkbox"/> Option III – PPO 2500		<input type="checkbox"/> Option V – PPO 7500	
	<input type="checkbox"/> Option II – PPO 1000		<input type="checkbox"/> Option IV – PPO 5000		<input type="checkbox"/> Option VI – PPO 10000	
Effective Date Requested: _____ <small>Subject to MCHA approval. Cannot be prior to receipt date by MCHA.</small>						

ELIGIBILITY QUESTIONNAIRE	<p>I hereby apply for the MCHA Portability Plan. I understand that I must apply for this Plan within 63 days of the loss of my most recent group coverage. All of the following questions must be answered so the lead carrier can determine my eligibility for the Portability Plan.</p>					
	<p>1. Are you a resident of Montana? <input type="checkbox"/> Yes <input type="checkbox"/> No Please attach two items as proof of your physical address in Montana (e.g., driver's license, recent receipts, state income tax return, house payment records, employment records).</p>					
	<p>2. Do you have an employer group health plan, governmental plan, or church plan that has ended or will be ending? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
	<p>3. Was your most recent coverage an employer group health plan, a governmental plan, or a church plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
	<p>4. Have you had 18 months of creditable coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No 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.</p>					
	If you answer NO to Question 2, 3, or 4, STOP; you are NOT eligible for the MCHA Portability Plan.					
	<p>5. Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide your employer's name and address. _____ Does your employer sponsor a health benefit plan? If yes, you may not be eligible for this plan. <input type="checkbox"/> Yes <input type="checkbox"/> No Does your spouse's employer sponsor a health benefit plan? If yes, please explain why you are not covered on that plan. You may not be eligible for the MCHA Portability Plan. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
	<p>6. Do you have COBRA continuation coverage available through your most recent employer group health benefit plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did you elect that COBRA continuation coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If you are on COBRA continuation coverage, is that coverage exhausted? Please include supporting documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Date coverage ends: _____</p>					
	<p>If you are eligible for COBRA or a similar state program, you must elect coverage and exhaust it. You are NOT eligible for Portability coverage until your continuation coverage has been exhausted. (If you have more than two months until your continuation coverage ends, please apply for this Plan at a later date.)</p>					
	<p>7. Do you have other comprehensive health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Are you eligible for coverage under a group health plan (including your spouse's plan) or Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Is your medical care covered by Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
If you answer YES to Question 7, 8, or 9, STOP; you are NOT eligible for the MCHA Portability Plan.						

Applicant Name:

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Provide a history of your most recent 18 months of coverage. Include supporting documentation* (i.e., certificates of creditable coverage). Incomplete information may delay the processing of your application.

* If you do not receive a certificate of creditable coverage, you may also provide other supporting documentation to verify the period of prior coverage or you may provide a telephone number to contact your former insurer for purposes of telephonic confirmation. Supporting documentation includes items such as Explanation of Benefit forms, correspondence from a health plan or issuer, pay stubs showing a payroll deduction for health insurance, a copy of your health insurance ID card, provider records indicating period of coverage, third party statements verifying period of coverage, or any other relevant documents that include evidence of the period of coverage.

Coverage History

Existing or Most Recent Employer Group Health Benefit Plan, Governmental Plan, or Church Plan

Employer Name, ID Number, Address, Telephone Number, Insurance Company Name, Coverage Start Date, Coverage End Date, Reason Coverage Ended, Please check if either apply: Self-Funded Group Plan, Governmental Plan

Previous Coverage: List Employer Group Health Plan Name or Subscriber Name if Individual Coverage

Employer or Subscriber Name, ID Number, Address, Telephone Number, Insurer or Plan Name, Coverage Start Date, Coverage End Date, Reason Coverage Ended, Please check if either apply: Self-Funded Group Plan, Governmental Plan, Church Plan

IMPORTANT

This Electronic Funds Transfer (EFT) Authorization section needs to be completed only if this is the payment method you have selected.

Electronic Funds Transfer (EFT) Authorization

To (Name, City, and State 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.

Table with 2 columns: Date (mo / day / yr), Subscriber ID, Type of Account (Checking Account, Savings Account), Account Number, 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.

Applicant Name:

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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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	3. Have you advised the Applicant that if his or her Application does not contain an accurate record of his or her information, coverage may be subject to rejection or termination? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	4. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	_____	_____	_____	_____	_____
	Name	Address	City	State	ZIP Code
	_____	_____	_____	_____	_____
	Disability Insurance State License Number		Tax ID Number	Telephone Number	
	_____	_____	_____	_____	
	Signature		Date	BCBSMT Agent Number (if applicable)	
	_____	_____	_____	_____	
Conditions of Enrollment	I certify that my answers and statements are true and complete to the best of my knowledge.				
	I certify that I am not eligible for any other individual or group comprehensive health insurance coverage. 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 omission, concealment of facts, incorrect statement, 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 is guilty of a crime under Montana Code 33-1, Part 12. I enclose payment for one month's premium.				
	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.				
	Signature of Applicant DO NOT PRINT		Signature Date mo / day / yr		
	_____		/ /		
Lead Carrier Use Only	Group No. _____	Effective Date _____	Package Number _____	_____	
	Approved _____	Date _____	Rejected _____	Date _____	_____



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