

CHAND HIPAA* Membership Application

*Health Insurance Portability and Accountability Act of 1996 (HIPAA)





DCN

29306537 Rev. 8-09
BPN _____

Please type or print in black ink. Press firmly.

CHAND HIPAA Membership Application

GROUP ROLL _____

1. APPLICANT'S INFORMATION			GROUP ROLL _____	
Last Name	First	M.I.	Social Security Number	
Mailing Address			State in Which You Reside	
City	State	Zip Code	Home Phone () -	
Requested Effective Date (mm-dd-yy)			Birth Date (mm-dd-yy)	
			Sex <input type="checkbox"/> M <input type="checkbox"/> F	

2. SPOUSE/DEPENDENT INFORMATION (Use extra paper if necessary)				
First Name	M.I.	Last (if different)	Relationship	Birth Date (mm-dd-yy)
Address:				- -
Address:				- -
Address:				- -

3. ELIGIBILITY

I am eligible for coverage because:

- I am a resident of North Dakota and intend to maintain North Dakota residency while a Subscriber with CHAND.
- I meet the federally-defined eligibility guidelines that follow:
 - I have had 18 months of Qualifying Previous Coverage, *(verification of Qualifying Previous Coverage is required; reference back page for definition of Qualifying Previous Coverage)*; and
 - I have applied for coverage within 63 days of the termination of the Qualifying Previous Coverage; and
 - I am not eligible for coverage under Medicare or a group health benefit plan; and,
 - I do not have any other health insurance coverage; and
 - I have not had the most recent Qualifying Previous Coverage terminated for nonpayment of premiums or fraud; and
 - If offered the option I have elected continuation coverage under COBRA through my employer or under a similar state program and that coverage has been exhausted. *(verification that your continuation coverage has been exhausted is required)*.
- I am not enrolled in health benefits with the state of North Dakota's Medical Assistance Program (Medicaid).
- My health insurance premiums are not paid for or reimbursed under any government sponsored program, government agency, health care provider, nonprofit charitable organization or my employer.

I certify that the above information is true.

Signature

Date

4. COVERAGE INFORMATION

I am applying for: \$500 Deductible \$1,000 Deductible

Yes No I want to purchase the optional chiropractic endorsement.

5. PREMIUM PAYMENT

5A. Initial Premium

Application will not be processed unless full initial premium has been submitted with the application.

- If the requested effective date is the 1st through the 15th of the month, submit one month's premium, which pays for coverage to the 1st of the next month.
- If the requested effective date is the 16th through the end of the month, submit one and one-half month's premium, which pays for coverage to the 1st of the second full month.

**Make check payable to CHAND. Mail your application and premium to:
Comprehensive Health Association of North Dakota
PO Box 6005, Fargo, ND 58108-9952**

5B. Payment Method

I wish to be billed: Bill Direct Automatic Payment Withdrawal *(If chosen, complete the following information and include voided check.)*

Name of Financial Institution _____

City _____

Account Number _____

Checking Account Savings Account

I hereby authorize my financial institution to deduct the current premium from my checking or savings account and remit the same to CHAND. This authorization is to continue in effect until revoked by me in writing. A 30-day notice is needed when cancelling an automatic withdrawal authorization. CHAND is not responsible for overdrafts and fees due to insufficient funds in my account.

Signature _____

Relationship to Applicant _____

6. OTHER COVERAGE INFORMATION (Attach Certificate(s) of Coverage if available or provide other verification of your Qualifying Previous Coverage Failure to provide this information may affect your ability to qualify as an eligible CHAND HIPAA individual.)

Medical Assistance - State of North Dakota (Medicaid)

- Yes No Are you currently enrolled in the state of North Dakota's Medical Assistance Program? **If yes, STOP! You are not eligible to complete a CHAND application while you are enrolled in the state of North Dakota's Medical Assistance Program.**
- Yes No Have you ever been enrolled in the state of North Dakota's Medical Assistance Program? If yes, please provide documentation to support the termination of enrollment and complete this section.

Medicaid Client ID Number (10 digits)	Coverage Dates (mm-dd-yy) From ___ - ___ to ___ - ___	Name registered with Medicaid (if different)
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Medicare

- Yes No Are you currently covered by Medicare? **If yes, STOP! You are not eligible to complete a CHAND HIPAA application while you are covered by Medicare.**

Qualifying Previous Coverage (You may not complete this application if it has been more than 63 days since your Qualifying Previous Coverage terminated.)

Previous Coverage Company Name	Company Phone Number	Policy Number	Policyholder (first, m.i., last name)	Birth Date (mm-dd-yy) - -
Coverage Dates (mm-dd-yy) From ___ - ___ to ___ - ___	Name(s) of Person(s) Covered			

- Yes No Did this coverage provide maternity benefits?

Prior Comprehensive Health Association of North Dakota Coverage (CHAND)

- Yes No Have you previously been enrolled in the CHAND program? **If yes, when?** From ___ - ___ to ___ - ___
(mm-dd-yy) (mm-dd-yy)

Policyholder with prior CHAND coverage	Last	First
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Workers' Compensation/No-Fault

- Yes No Are you currently receiving or have you previously received workers' compensation benefits?
- Yes No Are you currently receiving or have you previously received no-fault benefits?

Injury Date (mm-dd-yy) - -	Type of Injury	Company Providing Benefits	Company Phone Number
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7. SIGNATURE(S) (This form must be signed and dated)

I understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted until the Benefit Plan is issued to me. I have read this application in its entirety (including the back page) and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any Benefit Plan(s) issued based on this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

X _____
Applicant's Signature Date Signed

X _____
Parent's Signature (if Applicant is under age 18) Date Signed

Date App Received - -	Amount Received with App \$ _____ . ____	Check Number		
Agent Name (please print)	Agent/License Number	Social Security Number - -	Telephone Number () -	
Company Name	Address	City	State	Zip Code



EFFECTIVE DATE

Your effective date may be:

- the signature date of application; or,
- any date after the signature date of application, but less than 64 days following termination of previous coverage.

DEFINITION OF QUALIFYING PREVIOUS COVERAGE:

With respect to an individual, health benefits or coverage provided under any of the following:

- A group health benefit plan;
- A health benefit plan;
- Medicare;
- Medicaid;
- TRICARE (the health care program for military dependents and retirees);
- A medical care program of the Indian health service or of a tribal organization;
- A state health benefit risk pool, including coverage issued under N.D. Cent. Code §26.1-08;
- A health plan offered under §5 U.S.C. 89;
- A public health plan as defined in federal regulations, including a plan maintained by a state government, the United State government or a foreign government;
- A health benefit plan under §5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)]; and
- A state children's health insurance program (SCHIP).

If you have questions or require assistance when completing this application, please contact any licensed agent who sells health insurance in North Dakota or our office listed below:

Comprehensive Health Association of North Dakota

4510 13th Ave. S.
Fargo, ND 58121
Phone: (701) 277-2271



**CHAND Service
Center Toll-Free
(800) 737-0016**