

CHAND Traditional Membership Application





DCN _____

20000220 Rev. 11-09
BPN _____

Please type or print in black ink. Press firmly.

CHAND Traditional Membership Application

1. APPLICANT'S INFORMATION				GROUP ROLL _____	
Last Name		First		M.I.	
Mailing Address					
City		State		Zip Code	
Requested Effective Date (mm-dd-yy)		Birth Date (mm-dd-yy)		Date You Became a North Dakota Resident	
-		-		-	
				Work Phone () -	
				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:					

3. ELIGIBILITY

I am eligible for coverage because:

- I have been a resident of North Dakota for at least 183 days prior to this application and intend to maintain North Dakota residency while a Subscriber of CHAND.
- I am
 - 1. the resident dependent of a CHAND subscriber; or,
 - 2. the resident spouse of a CHAND subscriber. **OR**
- I have included written evidence from at least one insurance carrier that within 180 days prior to the signature date of application, I have been:
 - 1. rejected or refused by an insurer to issue substantially similar insurance for health reasons;
 - 2. offered coverage with a restrictive rider or a preexisting condition limitation placed on my policy, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk; or,
 - 3. offered comparable insurance at a rate exceeding the CHAND rate **OR**
- I have included written evidence from a medical professional that I have been treated or diagnosed with of any of the following:
In answering these questions, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic disease for which you believe you may be at risk.
 - AIDS
 - Alzheimer's disease
 - Cirrhosis
 - COPD/emphysema
 - Crohn's disease
 - Dementia
 - End stage renal failure
 - Hemiplegia/paraplegia if result of CVA
 - Hemochromatosis
 - Hemophilia
 - Multiple sclerosis
 - Muscular dystrophy
 - Nursing home resident
 - Obesity - BMI (Body Mass Index) > 33
 - Polycythemia
 - Pregnancy
 - Quadriplegia
 - Severe osteoarthritis
- I have included within 90 days after the date, written evidence that my lifetime maximum coverage amount was reached on my most recent health insurance coverage. *(Premium for coverage retroactive to the date that lifetime maximum occurred is required to be submitted with the application.)*
- I am not enrolled in health benefits with the state of North Dakota's Medical Assistance Program (Medicaid).
- I am not imprisoned under federal, state or local authority.
- 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 have not been insured through CHAND during the last 12 months. *(This does not apply to an applicant who has applied under 2d above.)*

I certify that the above information is true.

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 information below.)
Include voided check

Name as Shown on Account (print) _____

Name of Financial Institution _____

City _____

Bank Routing Number (first 9 digits on lower left side of check) _____

Account Number _____

Checking Account Savings Account

Is This a Business Account? Yes No

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 _____ Date _____

This application will not be accepted without the necessary written evidence noted above.

6. OTHER COVERAGE INFORMATION (Attach Certificate(s) of Coverage or other documentation from your previous health insurance company. FAILURE TO PROVIDE DOCUMENTATION MAY AFFECT YOUR WAITING PERIOD.)

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, please complete this section.

Name registered with Medicare (if different)	Medicare ID Card Number (include alpha characters)
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Hospital Part A Effective Date <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - 01 - <input type="checkbox"/> <input type="checkbox"/>	Medical Part B Effective Date <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - 01 - <input type="checkbox"/> <input type="checkbox"/>	Prescription Drug Part D Effective Date <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> - 01 - <input type="checkbox"/> <input type="checkbox"/>
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Other Health Benefit Plan

- Yes No Are you currently or have you previously been covered by another health benefit plan(s)? If yes, please complete this section.

Other Coverage Company Name	Company Phone Number	Policy Number	Policyholder (first, m.i., last name)	Birth Date (mm-dd-yy)
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Coverage Dates (mm-dd-yy) From ____ - ____ to ____ - ____	Name(s) of Person(s) Covered
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- Yes No Does this coverage provide maternity benefits?
- Yes No Do you intend to keep your current policy in force after the effective date of this application? _____

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

FOR OFFICE USE ONLY (Please print)

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

CHAND

Comprehensive Health Association
of North Dakota



EFFECTIVE DATE

Your effective date is based on the eligibility option you have selected in [Section 3 Eligibility](#). Please reference the first page of this application. Individuals applying as an:

Applicant who checked 2a box 1 or 2 your effective date will be the signature date of application.

Applicant who checked 2b box 1 your effective date may be:

- the day following the date shown on the written evidence;
- the signature date of application, if it is at least one day and less than 180 days following the date shown on the written evidence; or,
- any date after the signature date of application if the date is at least one day and less than 180 days following the date shown on the written evidence.

Applicant who checked box 2b box 2 or 3 your effective date may be:

- the signature date of application; or,
- any date after the signature date of application, but less than 180 days following the date shown on the written evidence.

Applicant who checked any of the conditions listed in 2c your effective date may be:

- the signature date of application; or,
- any date after the signature date of application, but less than 180 days following the date shown on the written evidence.

Applicant who applied under 2d your effective date may be the date the lifetime maximum occurred if the application is:

- submitted within 90 days after the date that the lifetime maximum occurred; and
- accompanied by premium for coverage retroactive to the date that the lifetime maximum occurred.

LIMITATIONS AND EXCLUSIONS

I understand that a Waiting Period of 180 consecutive days beginning on the effective date of this Benefit Plan must be fulfilled before benefits will be available for any services, supplies or charges for the treatment of any condition for which medical advice, diagnosis, care or treatment was recommended or received during the 180 days immediately preceding the signature date of application. The Waiting Period does not apply to nonelective treatment or procedures for congenital or genetic diseases. The waiting period does not apply to an applicant who has obtained coverage due to reaching the lifetime maximum coverage amount on their most recent health insurance coverage.

I understand that a Waiting Period of 270 consecutive days beginning on the effective date of this Benefit Plan must be fulfilled before benefits will be available for maternity services. Exception: A Subscriber who qualifies for coverage due to a catastrophic condition or major illness who is also pregnant at the time of application for coverage will be eligible for maternity benefits after completing a Waiting Period of 180 consecutive days of coverage.

The Waiting Period may be reduced by Qualifying Previous Coverage, if the signature date of application and the effective date of this Benefit Plan are no more than 63 days following termination of previous coverage.

The CHAND Board of Directors, by a two-thirds majority vote, may exempt a Subscriber from the provisions of the Waiting Periods when required under emergency circumstances to allow the applicant access to medical procedures determined to be necessary to preserve life.

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**