

CHAND Supplement Membership Application

*for Individuals Age 65 and Older
or with Disabilities who are
eligible for Medicare*





DCN _____

20000281 Rev. 11-09
BPN _____

Please type or print in black ink. Press firmly.

CHAND Supplement Membership Application

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

3. ELIGIBILITY

I am eligible for coverage because:

- I am at least 65 years old or disabled and eligible for Medicare.
- 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.

<input type="checkbox"/> AIDS	<input type="checkbox"/> Hemiplegia/paraplegia if result of CVA	<input type="checkbox"/> Obesity - BMI (Body Mass Index) > 33
<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Hemochromatosis	<input type="checkbox"/> Polycythemia
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> COPD/emphysema	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Quadriplegia
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Muscular dystrophy	<input type="checkbox"/> Severe osteoarthritis
<input type="checkbox"/> Dementia	<input type="checkbox"/> Nursing home resident	
<input type="checkbox"/> End stage renal failure		

I certify that the above information is true.

Signature _____ Date _____

4. COVERAGE INFORMATION

CHAND Supplement Plan:
 Basic Standard

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.

Authorized Signature as Shown on Account _____
 Retain a copy of this authorization for your records.

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



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 3a box 1 or 2 your effective date will be the signature date of application.

Applicant who checked 3b 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 3b 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 3c 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.

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.

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**