

CHAND TAARA* Membership Application

*Federal Trade Adjustment Assistance Reform Act of 2002 (TAARA)





DCN

29306538 Rev. 8-09
BPN _____

Please type or print in black ink. Press firmly.

CHAND TAARA Membership Application

GROUP ROLL _____

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

3. ELIGIBILITY
<p>I am eligible for coverage because:</p> <ol style="list-style-type: none"> 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 a Trade Adjustment Assistance or Pension Benefit Guarantee Corporation applicant. <i>(please attach a copy of your Health Coverage Tax Credit (HCTC) candidate letter).</i> I have had three or more months of qualifying previous health insurance coverage at the time of application. I have applied for coverage within 63 days of termination of qualifying previous health insurance coverage <i>(please attach Certificate(s) of Coverage or other documentation from your previous health insurance company).</i> I am not imprisoned under federal, state, or local authority. I am not enrolled in health benefits with the state of North Dakota's Medical Assistance Program (Medicaid). I have not been insured through CHAND during the last 12 months. I do not have health insurance coverage through any of the following: <ol style="list-style-type: none"> My or my spouse's employer plan that provides for employer contribution of 50 percent or more of the cost of coverage of myself, my spouse and my eligible dependents or the coverage is in lieu of an employer's cash or other benefit under a cafeteria plan; North Dakota's children's health insurance program (Healthy Steps); A government plan; Chapter 55 of United States Code Title 10 relating to armed forces medical and dental care; or Medicare. Coverage under this program may be provided to an applicant who is eligible for health insurance coverage through COBRA [Pub. L. 99-272; 100 Stat. 82]; a spouse's employer program in which the employer contribution is less than 50 percent; or the individual marketplace, including continuation or guaranteed issue, but who elects to obtain this coverage. <p>I certify that the above information is true.</p> <p>Signature _____ Date _____</p>

5. PREMIUM PAYMENT
<p>5A. Initial Premium</p> <p>If you choose bill direct or automatic payment withdrawal, your application will not be processed unless full initial premium has been submitted with the application.</p> <ul style="list-style-type: none"> 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. <p>Make check payable to CHAND. Mail your application and premium to: Comprehensive Health Association of North Dakota PO Box 6005, Fargo, ND 58108-9952</p>
<p>5B. Payment Method</p> <p>Please see the back of this application for important billing and payment information.</p> <p>I wish to be billed:</p> <p><input type="checkbox"/> Bill Direct</p> <p><input type="checkbox"/> Automatic Payment Withdrawal <i>(If chosen, complete the following information and include voided check.)</i></p> <p><input type="checkbox"/> Payment through Health Coverage Tax Credit (HCTC) Processing Center</p> <p>Name of Financial Institution _____</p> <p>City _____</p> <p>Account Number _____</p> <p><input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account</p> <p><i>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.</i></p> <p>Signature _____</p> <p>Relationship to Applicant _____</p>

4. COVERAGE INFORMATION
<p>I am applying for: <input type="checkbox"/> \$500 Deductible <input type="checkbox"/> \$1,000 Deductible</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No I want to purchase the optional chiropractic endorsement.</p>

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

6. TAARA QUALIFIED INDIVIDUAL (If applicant is not the qualified individual.)

First Name	M.I.	Last (if different)	Birth Date (mm-dd-yy)	Social Security Number
			- -	- - -

7. OTHER COVERAGE INFORMATION (Attach Certificate(s) of Coverage or other documentation from your previous health insurance company. Failure to provide documentation may affect your ability to qualify as an eligible CHAND TAARA 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 TAARA application while you are covered by Medicare.**

Previous Health Benefit Plan (You may not complete this application if it has been more than 63 days since your qualifying previous health insurance 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?

Other Health Benefit Plan

- Yes No Are you currently 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)
				- -
Coverage Dates (mm-dd-yy) From - - to - -	Name(s) of Person(s) Covered			

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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8. 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**

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

CHAND

Comprehensive Health Association
of North Dakota



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.

IMPORTANT INFORMATION ABOUT BILLING AND PAYMENT

1. **HCTC Processing Center:** Beginning on August 1, 2003, persons eligible for the Health Coverage Tax Credit may receive the credit in advance by enrolling with the HCTC Processing Center. The HCTC Processing Center will collect 35 percent of the total monthly premium from you and each of your covered family members and pay your 35 percent share and the remaining 65 percent to CHAND.

If you choose this option, you are responsible for sending the HCTC Processing Center the initial billing statement from CHAND and making timely payment to the HCTC Processing Center. If CHAND does not receive the full premium amount from the HCTC Processing Center, you may lose your coverage.

2. **Contacting the HCTC Processing Center.** The HCTC Processing Center Customer Contact line is 1-866-628-HCTC. You should contact the HCTC Processing Center about enrolling for the advanced tax credit as soon as you apply for CHAND coverage.
3. **Rates.** You will pay a separate age-based rate for each member of your family covered by CHAND. CHAND does not offer a family rate.
4. **Rate increases.** CHAND's rates may increase from time to time. You will have 31 days' notice of any increase. You must **immediately** notify the HCTC Processing Center of the increase, so that it sends the correct full premium to CHAND. **If CHAND does not receive the full premium amount from the HCTC Processing Center, you may lose your coverage.**
5. **Paying CHAND directly.** If you choose to pay premiums to CHAND directly through monthly billing or automatic payment withdrawal, you will not be able to receive the advance tax credit. You must pay CHAND IN FULL for all premiums due and claim your tax credit on your tax return.

If the premiums are not paid in full within 31 days after the due date, your coverage will end.

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**