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.

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.

Contact Us

CHAND Services toll-free: 844-363-8457

Comprehensive Health Association of North Dakota

4510 13th Ave. S.
Fargo, ND 58101
Phone: (844) 363-8457
MEDICARE HEALTH INSURANCE

Entitled To:

HOSPITAL (PART A) 
MEDICAL (PART B) 

MEDICARE NUMBER

I, the applicant, am: 

[ ] the resident spouse of a CHAND subscriber; OR

[ ] the resident dependent of a CHAND subscriber; OR

[ ] offered comparable insurance at a rate exceeding the CHAND rate; OR

[ ] 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

[ ] rejected or refused by an insurer to issue substantially similar insurance for health reasons; OR

[ ] the resident spouse of a CHAND subscriber. 

I have included written evidence from at least one insurance carrier that within 180 days prior to the signature date while a subscriber of CHAND. 

I have included written evidence from a medical professional that I have been treated or diagnosed with any of the following: 

AIDS  Multiple sclerosis  Dementia  Polycythemia
Alzheimer’s disease  Hypothyroidism  Emphysema  Pregnancy
Cirrhosis  Stroke  COPD/AIDS  Quadriplegia
CROhn’s disease  Hemophilia  End stage renal failure  Severe osteoarthritis
Hemochromatosis  Multiple myeloma  Hemiplegia/Paresis  Duchenne muscular dystrophy

OR

Are you currently enrolled in the state of North Dakota’s Medical Assistance Program (Medicaid)? 

[ ] Yes  [ ] No 

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. 

Prior Comprehensive Health Association of North Dakota Coverage (CHAND) 

[ ] Yes  [ ] No 

If Yes, have you previously been enrolled in the CHAND program? If yes, when? 

From ______/_____/______ to ______/_____/______

Policyholder name with prior CHAND coverage

Last  First

STEP 2: SPOUSE/DEPENDENT (Use extra paper if necessary)

First Name  Middle Initial  Last Name  Gender  Male  Female

Address

Date of Birth (Month/Day/Year)

STEP 3: ELIGIBILITY

I am eligible for coverage because

1. I am at least 65 years old or disabled and eligible for Medicare.
2. 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.
2a. I am 

[ ] 1. the resident dependent of a CHAND subscriber; OR

[ ] 2. the resident spouse of a CHAND subscriber; OR

2b. 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

2c. I have included written evidence from a medical professional that I have been treated or diagnosed with 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  [ ] Emphysema  [ ] Multiple sclerosis
[ ] Alzheimer’s disease  [ ] COPD/AIDs  [ ] Muscle dystrophy
[ ] Cirrhosis  [ ] End stage renal failure  [ ] Nursing home resident
[ ] CROhn’s disease  [ ] Hemiplegia/Paresis  [ ] Obesity - BMI
[ ] Hemochromatosis  [ ] Result of CVA  [ ] (Body Mass Index) > 33

[ ] Polycythemia  [ ] Duchenne muscular dystrophy  [ ] Severe osteoarthritis

3. I am not enrolled in health benefits with the state of North Dakota’s Medical Assistance Program (Medicaid).
4. I am not imprisoned under federal, state or local authority.
5. 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.
6. I have not been insured through CHAND during the last 12 months.

I certify that the above information is true.

STEP 4: COVERAGE INFORMATION

I am applying for: 

[ ] Basic (Group 10349802)  [ ] Standard (Group 10349801)

STEP 5: PREMIUM PAYMENT

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: Blue Cross Blue Shield of ND PO Box 857668 Minneapolis, MN 55485-7668

Failure to provide documentation may affect your waiting period.

Attach Certificate(s) of Coverage or other documentation from your previous health insurance company.

Failure to provide documentation may affect your waiting period. 

STEP 6: OTHER COVERAGE INFORMATION

Medical Assistance - State of North Dakota (Medicaid) 

[ ] Yes  [ ] No

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.

Prior Comprehensive Health Association of North Dakota Coverage (CHAND) 

[ ] Yes  [ ] No

If Yes, have you previously been enrolled in the CHAND program? If yes, when? 

From ______/_____/______ to ______/_____/______

Company Name  Address  City  State  ZIP

Amount Received with App

Check Number

Producer Name (please print)

NPN (National Producer Number)  Phone Number

Make check payable to CHAND. Mail your application and premium to: Blue Cross Blue Shield of ND PO Box 857668 Minneapolis, MN 55485-7668

STEP 7: SIGN, AUTHORIZE AND DATE APPLICATION

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.

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 (mm-dd-yy)

Amount Received with App

Check Number

Producer Name (please print)

NPN (National Producer Number)  Phone Number

Company Name  Address  City  State  ZIP
**STEP 1: APPLICANT’S NAME REGISTERED WITH MEDICARE AND APPLICANT’S MAILING ADDRESS**

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<thead>
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**Email Address (If applicable)**

**Step 2: SPOUSE/DEPENDENT** (Use extra paper if necessary)

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2a. I am ☐ The resident dependent of a CHAND subscriber; OR ☐ The resident spouse of a CHAND subscriber; OR
2b. 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
2c. I have included written evidence from a medical professional that I have been treated or diagnosed with any of the following:

   AIDS ☐ Alzheimer’s disease ☐ Cirrhosis ☐ COPD/emphysema ☐ End stage renal failure ☐ Hemochromatosis ☐ Hemophilia ☐ Multiple sclerosis ☐ Myocardial dystrophy ☐ Nursing home resident ☐ Obese - BMI (Body Mass Index) > 33 ☐ Polycthemia ☐ Pregnancy ☐ Quadriplegia ☐ Severe osteoarthritis

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.

**Step 4: COVERAGE INFORMATION**

I am applying for ☐ Basic (Group 10349802) ☐ Standard (Group 10349801)

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**Step 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.

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 _____ / _____ / _____

**Policyholder name with prior CHAND coverage**

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**Step 7: SIGN, AUTHORIZE AND DATE APPLICATION**

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X

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<tr>
<th>Applicant’s Signature</th>
<th>Date Signed</th>
<th>Parent’s Signature (If applicant is under age 18)</th>
<th>Date Signed</th>
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**FOR OFFICE USE ONLY (PLEASE PRINT)**

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<th>Producer Name (please print)</th>
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**Step 8: MEDICARE HEALTH INSURANCE**

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<tr>
<td>MEDICAL (PART B)</td>
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</table>

**Step 9: SIGNATURE**

Signature

Date

[29379178 IND]
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:

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:

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- 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.

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.

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Contact Us

CHAND Services toll-free: 844-363-8457

Comprehensive Health Association of North Dakota

4510 13th Ave. S.
Fargo, ND 58101
Phone: (844) 363-8457

Complete this application in its entirety in blue or black ink. Do not use a pencil or a highlighter.