CHAND
Comprehensive Health Association of North Dakota

CHAND HIPAA Membership Application

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

Eff. 9/1/2018
Filed 9/24/2018
29379176 IND
1-21

STEP 1: APPLICANT'S INFORMATION

Please note: Processing of your application may be delayed if this form is NOT completed in its entirety. PLEASE PRINT CLEARLY.

First Name	MI	Last Name	Gender ☐ Male ☐ Female
Social Security Number	Date of Birth (Month/Day/Year) _____ /_____ /_____		Requested Effective Date _____ /_____ /_____

Mailing Address

City	State	ZIP	County
Home Phone	Work Phone		Mobile Phone

Email Address (If applicable)

Date You Became a North Dakota Resident (Month/Day/Year) _____ /_____ /_____

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

First Name	MI	Last Name	Gender ☐ Male ☐ Female
Relationship	Address		Date of Birth (Month/Day/Year) _____ /_____ /_____

STEP 3: ELIGIBILITY

I am eligible for coverage because:

1. I am a resident of North Dakota and intend to maintain North Dakota residency while a Subscriber with CHAND.
2. 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).*
3. I am not enrolled in health benefits with the state of North Dakota's Medical Assistance Program (Medicaid).
4. 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.

X	
Signature	Date

STEP 4: COVERAGE INFORMATION

I am applying for:
- $500 Deductible without chiropractic (10345505)
- $500 Deductible with chiropractic (10345507)
- $1,000 Deductible without chiropractic (10345506)
- $1,000 Deductible with chiropractic (10345508)

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 6005 Fargo, ND 58108-9952

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.**

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.

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	Last	First

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.

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 Recieved (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

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).

Contact Us

CHAND Services toll-free: 844-363-8457

Comprehensive Health Association of North Dakota

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