



# **CHAND HIPAA Membership Application**

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

**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)      \$1,000 Deductible without chiropractic (10345506)  
 \$500 Deductible with chiropractic (10345507)                      \$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 857668 Minneapolis, MN 55485-7668**

**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 \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Policyholder name with prior CHAND coverage</b>	Last	First
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**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

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**CHAND Services toll-free:** 844-363-8457

### **Comprehensive Health Association of North Dakota**

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Fargo, ND 58121  
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