CHAND
Comprehensive Health Association of North Dakota

CHAND TAARA 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
29379177 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 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.
2. I am a Trade Adjustment Assistance or Pension Benefit Guarantee Corporation applicant. (please attach a copy of your Health Coverage Tax Credit (HCTC) candidate letter).
3. I have had three or more months of qualifying previous health insurance coverage at the time of application.
4. I have applied for coverage within 63 days of termination of qualifying previous health insurance coverage (please attach Certificate(s) of Coverage or other documentation from your previous health insurance company).
5. I am not imprisoned under federal, state, or local authority.
6. I am not enrolled in health benefits with the state of North Dakota's Medical Assistance Program (Medicaid).
7. I have not been insured through CHAND during the last 12 months.
8. I do not have health insurance coverage through any of the following:
   - A. 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;
   - B. North Dakota's children's health insurance program (Healthy Steps);
   - C. A government plan;
   - D. Chapter 55 of United States Code Title 10 relating to armed forces medical and dental care; or
   - E. Medicare.
9. 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.

I certify that the above information is true.

X	
Signature	Date

STEP 4: COVERAGE INFORMATION

I am applying for: $500 Deductible without chiropractic (10345515)
$500 Deductible with chiropractic (10345517)
$1,000 Deductible without chiropractic (10345516)
$1,000 Deductible with chiropractic (10345518)

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.

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.

Contact Us

CHAND Services toll-free: 844-363-8457

Comprehensive Health Association of North Dakota

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