CHAND
Comprehensive Health Association of North Dakota

CHAND Supplement Application

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

Eff. 11/1/2019
Filed 9/24/2018
29379178 IND
4-21

APPLICANT'S NAME REGISTERED WITH MEDICARE AND APPLICANT'S MAILING ADDRESS

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

Mailing Address

City	State	ZIP	County
Home Phone	Work Phone		Mobile Phone

Email Address *(If applicable)*

Please fill out this card exactly as it appears on your Medicare card. BCBSND will be unable to process your claims if this information is not correct. You must be enrolled in both Hospital Part A and Medical Part B to be eligble for this Medicare Supplement Plan.

MEDICARE HEALTH INSURANCE

MEDICARE NUMBER

☐☐☐☐☐☐☐☐☐☐☐

ENTITLED TO	COVERAGE STARTS
HOSPITAL (PART A)	_____ - 01 - _____
MEDICAL (PART B)	_____ - 01 - _____

SPOUSE/DEPENDENT *(Use extra paper if necessary)*

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

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 of 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.

OR

☐ AIDS	☐ Dementia	☐ Hemophilia	☐ Polycythemia
☐ Alzheimer's disease	☐ End stage renal failure	☐ Multiple sclerosis	☐ Pregnancy
☐ Cirrhosis	☐ Hemiplegia/paraplegia *(If result of CVA)*	☐ Muscular dystrophy	☐ Quadriplegia
☐ COPD/emphysema		☐ Nursing home resident	☐ Severe osteoarthritis
☐ Crohn's disease	☐ Hemochromatosis	☐ Obesity – BMI *(Body Mass Index)* > 33	

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 terminated coverage through CHAND during the last 12 months.

I certify that the above information is true.

X	
Signature	Date

COVERAGE INFORMATION

I am under 65 and applying for:	☐ Basic (Group 10430427)	☐ Standard (Group 10430430)
I am over 65 and applying for:	☐ Basic (Group 10349802)	☐ Standard (Group 10349801)

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

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	Last	First

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 *(Month/Day/Year)* _____ /____ /_____	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 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

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