COMMUNITY Health Options™

Individual Enrollment Application

Phone: (855) 624-6463
Fax: (207) 402-3745

Mail Stop 100
PO Box 1121
Lewiston, ME 04243

Thank you for applying for Community Health Options individual coverage. All questions need to be completed and the application signed before your request will be processed. If you have any questions, please contact your Broker or call Community Health Options at (855) 624-6463.

Apply faster online

Apply faster online at www.HealthOptions.org

What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Policy numbers for any current health insurance

Why do we ask for this information?

We need this information to determine what coverage is available to you. We keep all the information you provide private and secure, as required by law.

What happens next?

Send your completed and signed application to:

Community Health Options
Mail Stop 100, PO Box 1121
Lewiston, ME 04243

Get help with this application

- Call Community Health Options at (855) 624-6463
- If you need help in a language other than English, call (855) 624-6463. Member Service will connect you with a translator for the language you need.
- TTY users should call 711.

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COMMUNITY Health Options™

Individual Enrollment/Change Form

PLEASE USE BLACK OR BLUE INK ONLY

Mail Stop 100, PO Box 1121
Lewiston, ME 04243
Fax: (207) 402-3745

If you have any questions, please contact Community Health Options at (855) 624-6463.

1. POLICY HOLDER INFORMATION

Please check appropriate item:

- ☐ 2021 Open Enrollment – New Enrollment
- ☐ 2021 Open Enrollment – Renew Coverage
- ☐ New Enrollment due to Life Event
- ☐ Change coverage due to Life Event

If you qualify for a Special Enrollment Period or Life Event, select an event reason:

- ☐ Marriage
- ☐ Divorce
- ☐ Birth or Adoption
- ☐ Turning 26 years of age
- ☐ Relocation to a new ZIP code, county or state
- ☐ Changes to citizenship or immigration status
- ☐ Losing access to other coverage (e.g. employer coverage)
- ☐ COBRA expiration
- ☐ Loss of minimum essential coverage
- ☐ Loss of Medicaid or CHIP
- ☐ Loss of eligibility to health insurance subsidies
- ☐ Court Order
- ☐ Chapter 11 Bankruptcy
- ☐ Release from incarceration
- ☐ Return from Military Service
- ☐ Other Qualifying Life Event _____

Event Date: _____

Supporting documentation is required. Failure to provide adequate documentation will cause delays in processing your enrollment changes. For more information about what types of supporting documentation will be accepted, please contact Member Services at (855) 624-6463

Policy Holder's Name (Last/First/Middle Initial)*		
Physical Address (Number and Street)*		Apartment or Suite Number
City*	State*	ZIP Code*
Mailing Address (if different from physical address)		
Telephone numbers* Home:	Work:	Marital Status ☐ Single ☐ Married
Email Address:*		

Items marked with an * are a required field.

2. POLICY HOLDER AND FAMILY INFORMATION*

Please complete information for eligible family members you wish to cover, delete or change

NAME(S) OF PERSON(S) (Last, First, MI)	Relationship to you	Date of Birth (mm/dd/yy)	Gender	Social Security Number (SSN) xxx-xx-xxxx	Has this person been a smoker within the last 6 months?	Will this person have other health insurance coverage while this coverage is in effect?	Name of Other Coverage	Certificate/ policy #
	SELF		☐ F ☐ M		☐ Y ☐ N	☐ Y ☐ N		
	SPOUSE/ DOMESTIC PARTNER		☐ F ☐ M		☐ Y ☐ N	☐ Y ☐ N		
	DEPENDENT		☐ F ☐ M		☐ Y ☐ N	☐ Y ☐ N		
	DEPENDENT		☐ F ☐ M		☐ Y ☐ N	☐ Y ☐ N		
	DEPENDENT		☐ F ☐ M		☐ Y ☐ N	☐ Y ☐ N		
	DEPENDENT		☐ F ☐ M		☐ Y ☐ N	☐ Y ☐ N		

Children may be covered as Dependents by their parents up until age 26. When a Dependent turns 26, coverage may continue until the end of the Calendar Year. If a Dependent listed above is a Disabled Dependent age 26 or older, please submit supporting documentation.

Is the application for this policy intended to replace an existing policy? ☐ Y ☐ N

3. PRIMARY CARE PROVIDER (PCP) ASSIGNMENT*

Selecting a Primary Care Provider (PCP) is required under all Community Health Options plans. You have the right to designate any PCP who participates in our network and who is available to accept you and/or your family members. PCPs are typically Family Practice, General Practice or Internal Medicine Doctors, Nurse Practitioners, or Certified Nurses/Midwives. For children, you may designate a pediatrician as your PCP. Our Provider Directory http://www.healthoptions.org/search-provider includes a list of Providers and information about providers who are part of our network.

Please complete information for assignment of Network Primary Care Providers for covered family members. If you do not assign a PCP, Community Health Options will assign one to you. You have the right to change your PCP at any time. PCP changes can be submitted through your Member portal or by contacting Member Services at (855) 624-6463.

Member Name (Last, First, MI)	Primary Care Provider Name (First, Last)	Practice Location

Items marked with an * are a required field.

4. MEDICAL COVERAGE * (Select one plan)

☐ **Community Safe Harbor PPO (Catastrophic)** $8,550 Individual/$17,100 Family Deductible To qualify for a catastrophic plan, you must be under 30 years old. Certain hardship events may also qualify.	☐ **Community Partner HMO (Silver)** $2,500 Individual/$5,000 Family Deductible Includes Chronic Illness Support
☐ **Community Secure HMO (Bronze)** $8,550 Individual/$17,100 Family Deductible	☐ **Community Capital HMO (Silver)** $2,500 Individual/$5,000 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program
☐ **Community Reliant HSA PPO (Bronze)** $6,800 Individual/$13,600 Family Deductible	☐ **Community Value HMO (Silver)** $3,350 Individual/$6,700 Family Deductible
☐ **Community Focus PPO (Bronze)** **$5,800 Individual/$11,600 Family Deductible** Includes Chronic Illness Support Program	☐ **Community Complete HMO (Silver)** $3,350 Individual/$6,700 Family Deductible Includes Pediatric Dental
☐ **Community Align PPO (Bronze)** $5,800 Individual/$11,600 Family Deductible Includes Pediatric Dental, Chronic Illness Support Program	☐ **Community Plus HMO (Silver)** $6,000 Individual/$12,000 Family Deductible
☐ **Community Best HMO (Bronze)** $5,500 Individual/$11,100 Family Deductible Includes Chronic Illness Support Program	☐ **Community Choice PPO (Silver)** $2,500 Individual/$5,000 Family Deductible
☐ **Community Asset PPO (Bronze)** $8,550 Individual/$17,100 Family Deductible Includes Chronic Illness Support Program	☐ **Community Advance PPO (Silver)** $2,500 Individual/$5,000 Family Deductible Includes Pediatric Dental
☐ **Community Foundation HMO (Silver)** $4,000 Individual/$8,000 Family Deductible	☐ **Community Vital PPO (Silver)** $2,300 Individual/ $4,600 Family Deductible
☐ **Community Delta HSA HMO (Silver)** $3,000 Individual/$6,000 Family Deductible	☐ **Community Edge PPO (Gold)** $2,000 Individual/$4,000 Family Deductible

Unless otherwise indicated, the policy does not include pediatric dental services. Pediatric dental coverage is included in some health plans, but can also be purchased as a stand-alone product. Please contact your insurance carrier or producer, or seek assistance through Healthcare.gov, if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

5. EFFECTIVE DATE

Open Enrollment

If your application for New or Renewed coverage is received by December 15th during the Annual Open Enrollment Period, your coverage will begin on January I, 2021.

Special Enrollment Period

If you are applying for coverage based on a Special Enrollment Period, the Effective Date of Coverage will be either the First of the month following the event or the First of the month following receipt of this application by Community Health Options, depending upon the type of qualifying event. In the case of birth or adoption, the Effective Date of Coverage will be the same as the Event Date.

Requested Effective Date: _____ /_____ /_____

Coverage will not begin until the first premium payment is received

Items marked with an * are a required field.

6. LEGAL ACKNOWLEDGEMENTS AND SIGNATURE

I understand that:

☐ **I am not currently eligible for a premium tax credit or have chosen not to apply for one. I understand checking this box DOES NOT disqualify me from obtaining a tax credit in the future should I become eligible.***

- I will receive notice by mail of my Membership status with Community Health Options once Community Health Options has received and processed my application. Upon notification of Membership, I will receive a Member ID Card, online access to the applicable Member Benefit Agreement and other necessary documents relating to my Community Health Options Membership coverage.
- I will receive by mail a statement for my first Premium payment. I understand that no claims will be processed under this coverage unless and until Community Health Options has received the total Premium due. If the Subscriber has a balance with Community Health Options from coverage within the prior 12 months, this prior balance will be due as part of the Binding Premium Payment. If the full amount due (including the prior balance) is not paid prior to the effective date of coverage, your coverage will not go into effect.
- If I decide not to accept coverage, I will send a written request to cancel coverage to Community Health Options, Mail Stop 100, PO Box 1121, Lewiston, ME 04243. I agree to return all materials to Community Health Options within 10 days after their delivery date. Community Health Options will refund any charges I have paid for the contract, and coverage will be null and void.
- If I or any covered family member is insured by more than one health contract, Coordination of Benefits will apply. Coordination of Benefits ensures that the total benefits received from all contracts do not exceed the actual cost of covered services.
- I am requesting coverage for myself and all dependents listed on this application. All applicants listed herein are Maine residents, or are otherwise eligible to purchase insurance from Community Health Options. To the best of my knowledge and belief, all statements and answers I have given are true and complete. I understand any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission, or cancellation of my coverage(s). I understand all benefits are subject to the conditions stated in the Member Benefits Agreement.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Applicant's Signature* _____

Print Name* _____

Date* _____ /_____ /_____

If you are the parent or legal guardian of a minor in a child-only policy and have signed the enrollment form, please provide the following information about yourself:

Name _____

Address _____

Phone Number (_____) _____ Relationship to Enrollee _____

Items marked with an * are a required field.

7. PRODUCER OF RECORD INFORMATION

Producer to complete (if applicable)		
The producer below has presented Community Health Options individual plans to the applicant. I have assisted the Applicant in the purchase of this policy.		
Producer's Name	Agency Name	Producer NPN
Address		
Producer's Signature _____ Date* _____ /_____ /_____		

Please send us the completed application by either Mail, Fax, or Email.

Mail to: Community Health Options, Mail Stop 100, PO Box 1121, Lewiston, ME 04243

Fax to: Community Health Options, 207-402-3745 | Email to: Enrollment@HealthOptions.org

Please call Member Services for Questions on how to fill out this form, 1-800-624-6463