2025 Individual Enrollment/Change Form

Instructions: Complete this form if you are applying for an individual or family health plan at Community Health Options. All questions must be completed before your request may 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 https://enroll.healthoptions.org/

- If you have already created an account, go to https://enroll.healthoptions.org/ehp/eapp/login to log in.

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, and our Member Services team will connect you with a translator for the language you need.
- TTY users should call 711.

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

1. POLICY HOLDER INFORMATION

Please check appropriate Item:

O New Coverage for 2025
O Renew Coverage for 2025
O New Enrollment due to life event
O Change coverage due to life event

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

O Marriage
O Divorce
O Birth or Adoption
O Turning 26 years of age
O Relocation to a new ZIP code, county, or state
O Loss of minimum essential coverage
O Loss of eligibility to health insurance subsidies
O COBRA expiration
O Changes to citizenship or immigration status
O Loss of Medicaid or CHIP
O Newly eligible for QSEHRA or ICHRA
O Became pregnant with no existing coverage
O Chapter 11 Bankruptcy
O Release from incarceration
O Return from military service
O Other qualifying life event _____

Event Date: _____

Policyholder'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:		

Supporting documentation is required for a Special Enrollment Period, or Life event. Failure to provide adequate documentation will delay the processing of your enrollment changes. For more information about what types of supporting documentation will be accepted, please contact Member Services at (855) 624-6463

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

COMMUNITY Health Options

2. POLICY HOLDER AND FAMILY INFORMATION

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

Policy Holder

Name (Last, First, Middle Initial)		Gender M / F	Race O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White
Date of Birth	Social Security Number	Ethnicity O Hispanic or Latino O Not Hispanic or Latino	
Will this person have other coverage while this policy is in effect? Y / N Name of Other Coverage: Certificate or Policy #:			Has this person used tobacco 4 or more times per week during the last 6 months? Y / N

Spouse/ Domestic Partner

Name (Last, First, Middle Initial)		Gender M / F	Race O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White
Date of Birth	Social Security Number	Ethnicity O Hispanic or Latino O Not Hispanic or Latino	
Will this person have other coverage while this policy is in effect? Y / N Name of Other Coverage: Certificate or Policy #:			Has this person used tobacco 4 or more times per week during the last 6 months? Y / N

Dependent

Name (Last, First, Middle Initial)		Gender M / F	Race O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White
Date of Birth	Social Security Number	Ethnicity O Hispanic or Latino O Not Hispanic or Latino	
Will this person have other coverage while this policy is in effect? Y / N Name of Other Coverage: Certificate or Policy #:			Has this person used tobacco 4 or more times per week during the last 6 months? Y / N

Dependent

Name (Last, First, Middle Initial)		Gender M / F	Race O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White
Date of Birth	Social Security Number	Ethnicity O Hispanic or Latino O Not Hispanic or Latino	
Will this person have other coverage while this policy is in effect? Y / N Name of Other Coverage: Certificate or Policy #:			Has this person used tobacco 4 or more times per week during the last 6 months? Y / N

Dependent

Name (Last, First, M.I.)		Gender M / F	Race O American Indian or Alaska Native O Asian O Black or African American O Native Hawaiian or Pacific Islander O White
Date of Birth	Social Security Number	Ethnicity O Hispanic or Latino O Not Hispanic or Latino	
Will this person have other coverage while this policy is in effect? Y / N Name of Other Coverage: Certificate or Policy #:			Has this person used tobacco 4 or more times per week during the last 6 months? Y / N

Children may be covered as dependents by their parents up to age 26. When a dependent turns 26, coverage may continue until the end of the calendar year. Please submit supporting documentation If a dependent listed above is a disabled dependent age 26 or older.

3. MEDICAL COVERAGE (Select one plan)

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.

O Health Options Clear Choice Catastrophic HMO NE $9,200 Individual/$18,400 Family Deductible To qualify for a catastrophic plan, you must be under 30 years old. Certain hardship events may also qualify.	**O Health Options Clear Choice Bronze $7200 HSA Plus PPO National Dental Off MP** $7,200 Individual/$14,400 Family Deductible Includes Pediatric Dental, Preventive Drug List
O **Health Options Clear Choice Bronze $9200 PPO National Dental Off MP** $9,200 Individual/$18,400 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental	**O Health Options Clear Choice Bronze $7200 HSA Plus PPO NE** $7,200 Individual/$14,400 Family Deductible Includes Preventive Drug List
O **Health Options Clear Choice Bronze $9200 PPO NE** $9,200 Individual/$18,400 Family Deductible Includes Chronic Illness Support Program	**O Health Options Clear Choice Bronze $6300 HSA Plus PPO National Dental Off MP** $6,300 Individual/$12,600 Family Deductible Includes Pediatric Dental, Preventive Drug List
O **Health Options Clear Choice Bronze $9200 HMO NE** $9,200 Individual/$18,400 Family Deductible Includes Chronic Illness Support Program	**O Health Options Clear Choice Bronze $6300 HSA PPO NE** $6,300 Individual/$12,600 Family Deductible
O **Health Options Bronze $8000 Healthy Maine PPO NE** $8,000 Individual/$16,000 Family Deductible Includes Chronic Illness Support Program, Wellness Program®	**O Health Options Clear Choice Silver $4500 HSA HMO Tiered NE Dental Off MP** $4,500/$5,400 Individual-$9,000/$10,800 Family Deductible Includes Pediatric Dental
O **Health Options Bronze $8000 Healthy Maine HMO National Off MP** $8,000 Individual/$16,000 Family Deductible Includes Chronic Illness Support Program, Wellness Program®	**O Health Options Clear Choice Silver $4200 PPO National Dental Off MP** $4,200 Individual/$8,400 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental
O **Health Options Bronze $8000 Healthy Maine HMO Tiered NE** $8,000/$9,200 Individual/ $16,000/$18,400 Family Deductible Includes Chronic Illness Support Program, Wellness Program®	**O Health Options Clear Choice Silver $4200 PPO NE** $4,200 Individual/$8,400 Family Deductible Includes Chronic Illness Support Program
O **Health Options Bronze $8000 Healthy Maine HMO NE** $8,000 Individual/$16,000 Family Deductible Includes Chronic Illness Support Program, Wellness Program®	**O Health Options Clear Choice Silver $4200 HMO Tiered NE Dental Off MP** $4,200/$5,040 Individual-$8,400/$10,080 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental
O **Health Options Clear Choice Bronze $7500 HMO Tiered NE Dental Off MP** $7,500/$9,000 Individual-$15,000/$18,000 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental	**O Health Options Clear Choice Silver $4200 HMO Tiered NE** $4,200/$5,040 Individual-$8,400/$10,080 Family Deductible Includes Chronic Illness Support Program
O Health Options Clear Choice Bronze $7500 HMO Tiered NE $7,500/$9,000 Individual-$15,000/$18,000 Family Deductible Includes Chronic Illness Support Program	**O Health Options Clear Choice Silver $4200 HMO NE** $4,200 Individual/$8,400 Family Deductible Includes Chronic Illness Support Program
O Health Options Clear Choice Bronze $7500 HMO NE $7,500 Individual/$15,000 Family Deductible Includes Chronic Illness Support Program	**O Health Options Silver $4000 HMO National Off MP** $4,000 Individual/$8,000 Family Deductible Includes Chronic Illness Support Program, Wellness Program®
O Health Options Clear Choice Bronze $7500 PPO National Dental Off MP $7,500 Individual/$15,000 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental	**O Health Options Clear Choice Silver $3500 PPO National Dental Off MP** $3,500 Individual/$7,000 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental
O Health Options Clear Choice Bronze $7500 PPO NE Dental $7,500 Individual/$15,000 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental	**O Health Options Clear Choice Silver $3500 PPO National** $3,500 Individual/$7,000 Family Deductible Includes Chronic Illness Support Program
O Health Options Clear Choice Bronze $7500 PPO NE $7,500 Individual/$15,000 Family Deductible Includes Chronic Illness Support Program	**O Health Options Clear Choice Silver $3500 PPO NE Dental Off MP** $3,500 Individual/$7,000 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental

3. MEDICAL COVERAGE (Continued)

O Health Options Clear Choice Silver $3500 PPO NE Dental $3,500 Individual/$7,000 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental	**O Health Options Clear Choice Gold $2500 PPO National Dental** $2,500 Individual/$5,000 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental
O **Health Options Clear Choice Silver $3500 PPO NE** $3,500 Individual/$7,000 Family Deductible Includes Chronic Illness Support Program	**O Health Options Clear Choice Gold $2500 PPO NE Dental** $2,500 Individual/$5,000 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental
O Health Options Clear Choice Silver $3500 HMO Tiered NE Dental Off MP $3,500/$4,200 Individual-$7,000/$8,400 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental	**O Health Options Clear Choice Gold $2500 PPO NE** $2,500 Individual/$5,000 Family Deductible Includes Chronic Illness Support Program
O Health Options Clear Choice Silver $3500 HMO Tiered NE $3,500/$4,200 Individual-$7,000/$8,400 Family Deductible Includes Chronic Illness Support Program	O **Health Options Clear Choice Gold $1500 PPO National Dental Off MP** $1,500 Individual/$3,000 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental. Wellness Program®
O Health Options Clear Choice Silver $3500 HMO NE Dental $3,500 Individual/$7,000 Family Deductible Includes Chronic Illness Support Program, Pediatric Dental	O **Health Options Clear Choice Gold $1500 PPO National** $1,500 Individual/$3,000 Family Deductible Includes Chronic Illness Support Program, Wellness Program®
O Health Options Clear Choice Silver $3500 HMO NE $3,500 Individual/$7,000 Family Deductible Includes Chronic Illness Support Program	O **Health Options Clear Choice Gold $1500 PPO NE** $1,500 Individual/$3,000 Family Deductible Includes Chronic Illness Support Program, Wellness Program®
O Health Options Clear Choice Silver $3500 HSA Plus PPO National Dental Off MP $3,500 Individual/$7,000 Family Deductible Includes Pediatric Dental, Preventive Drug List, Wellness Program®	**O Health Options Clear Choice Platinum PPO NE** $500 Individual/$1,000 Family Deductible Includes Chronic Illness Support, Wellness Program®
O Health Options Clear Choice Silver $3500 HSA PPO NE Dental Off MP $3,500 Individual/$7,000 Family Deductible Includes Pediatric Dental, Wellness Program®	

4. EFFECTIVE DATE

Open Enrollment

If your application for new or renewed coverage is received by December 15, 2024, during the annual Open Enrollment period, your coverage will begin on January 1, 2025.

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.

5. LEGAL ACKNOWLEDGEMENTS AND SIGNATURE

I understand that:

O 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_____

Date of Birth_____

Social Security Number_____

Address _____

Phone Number (__)_____Relationship to Enrollee _____

6. 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

For assistance completing this form, please contact the Member Services team at (855) 624-6463