



Traditional Plan Application and Federal High-Risk Pool Application

*Applications must be submitted within 30 days after losing prior coverage, except for the federal MAC Plan. For MCHA to determine whether or not credit can be given toward the preexisting exclusion period, you must submit your application before the 30-day time period ends. You can follow up with the documents necessary to determine eligibility for the Plan. Citizenship for the federal MAC Plan can be documented with a birth certificate or other acceptable documentation. Please visit www.mthealth.org, or call 1-800-447-7828, Extension 2128. if you have questions about the required documentation.

MCHA Plan	Deductible	Coinsurance	Maximum Annual Liability
Option I – Indemnity Plan 1000	\$1,000	80/20	\$5,000
Option II – PPO 1000	\$1,000	80/20 – 60/40	\$5,000
Option III – PPO 2500	\$2,500	80/20 – 60/40	\$6,750
Option IV – PPO 5000	\$5,000	80/20 – 60/40	\$9,500
Option V – PPO 7500	\$7,500	80/20 – 60/40	\$12,250
Option VI – PPO 10000	\$10,000	80/20 – 60/40	\$15,000
Option VII – Medicare Carveout PPO	\$1,000	80/20 – 60/40	\$5,000
Premium Assistance PPO 1000	\$1,000	80/20 – 60/40	\$5,000
Premium Assistance Medicare Carveout PPO 1000	\$1,000	80/20 – 60/40	\$5,000
Federal High-Risk Pool			
MAC Plan (Federal High-Risk Plan)	\$2,500	70/30 – 50/50	\$5,950

Enrollment in the federal MAC Plan is limited and on a first-come basis. The federal MAC plan is funded by insured's premium and federal funding. If the federal funding is not sufficient to cover the program expenses, insureds will have the option to move to an MCHA Traditional Plan of the insured's choice and the insured will be required to pay the regular MCHA premium.

Administered by
Blue Cross and Blue Shield of Montana
560 North Park Avenue
P.O. Box 4309
Helena, MT 59604-4309
1-800-447-7828, Extension 2128

APPLICATION FOR MCHA COVERAGE

Incomplete information may delay the processing of your application.

PLEASE TYPE OR PRINT IN BLACK INK

Applicant Information	Social Security Number (SSN) or work visa number (required for MAC Plan)			Date of Birth (mo / day / yr) / /		<input type="checkbox"/> Male <input type="checkbox"/> Female	
	Birthplace (Required for MAC Plan)			City		State	
	Last Name		First Name		Middle Initial		
	Applicant Residence Address			City	State	ZIP Code	County
	Applicant Mailing Address (if different from above)			City	State	ZIP Code	County
	Applicant Billing Address (if different from mailing address)			City	State	ZIP Code	Telephone Number
Traditional Plan Options	Select your option for coverage: <input type="checkbox"/> Option I – Indemnity Plan 1000 <input type="checkbox"/> Option IV – PPO 5000 <input type="checkbox"/> Option VII – Medicare Carveout PPO 1000 <input type="checkbox"/> Option II – PPO 1000 <input type="checkbox"/> Option V – PPO 7500 <input type="checkbox"/> Federal High-Risk Pool – MAC Plan <input type="checkbox"/> Option III – PPO 2500 <input type="checkbox"/> Option VI – PPO 10000 (Options I – VII may have a 12-month preexisting condition exclusion.) For the Medicare Carveout Premium Assistance Plan PPO 1000 and the Premium Assistance Plan PPO 1000, an additional form is required, and will serve as your option selection. (There may be a 4-month preexisting condition exclusion.) Effective Date Requested _____ <small style="text-align: center;">Subject to MCHA approval. Cannot be before receipt date by MCHA.</small>						
	1. Are you a resident of Montana? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for how long? Years _____ Months _____ 2. Are you a U.S. citizen or legally present? (Documentation required for MAC Plan only.) <input type="checkbox"/> Yes <input type="checkbox"/> No 3. How long have you been uninsured? _____ What was your last date of coverage? _____ 4. Please attach two items as proof of residency showing your physical Montana address (e.g., driver's license, recent receipts, state income tax return, house payment records, employment records). You must be a Montana resident for at least 30 days for all options (except the MAC Plan). 5. Are you covered by or eligible for Medicare? If yes, please attach a copy of your HIB or Medicare card. <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Are you enrolled for Medicaid coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Are you currently covered under any other comprehensive health insurance? If yes, please provide the carrier name, carrier telephone number, the cancellation date, and reason for the cancellation in the space below. Is this coverage a governmental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Or a self-funded group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Full Name and Telephone Number of Insurance Company or Carrier Name _____ Identification or Policy Number _____ Cancellation Date _____ Reason(s) for Cancellation _____ 8. If you are currently covered under other health insurance, are you applying for MCHA coverage because your premium rates are higher than the average premium rate used to calculate MCHA premiums (provided in MCA 33-22-1501(7)(B))? <input type="checkbox"/> Yes <input type="checkbox"/> No Submit a current summary of benefits and current rate for individual coverage. 9. Are you currently employed? If yes, please provide your employer's name and address. <input type="checkbox"/> Yes <input type="checkbox"/> No Does your employer sponsor a health benefit plan? Does your spouse's employer offer a health benefit plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to either question, were you denied coverage or provided coverage with a restrictive rider by reason of health? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain the circumstances that resulted in your rejection or the issuance of a restrictive rider. _____ Please provide the name of your employer's or your spouse's employer's carrier and the group policy number. _____ If you are employed and/or will be leaving employer group coverage, you may be a "federally defined eligible individual" and you should apply for coverage through the MCHA Portability Plan. Federally defined eligible individual means an individual for whom, as of the date of the application, has 18 months of other health insurance coverage which would qualify as "creditable coverage," who is not eligible for coverage under a group health plan, Social Security (Medicare), or Medicaid and who, if offered the option of continuation coverage under COBRA (or a state plan), has elected and exhausted that option. 10. Have you had continuous coverage for any time immediately preceding this application with a cancellation date within 30 days prior to the date of submitting this application? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide your original effective date of that coverage and attach a termination letter showing your cancellation date from your previous insurance coverage. If cancellation is dependent on obtaining MCHA coverage, submit a copy of the termination letter after coverage ends. Credit may be given toward the satisfaction of the preexisting condition limitation. _____ Creditable coverage is coverage that you had under any combination of the following plans, programs, and coverages: a group health plan, health insurance coverage, Medicare, TRICARE, Medicaid, Federal Employee Health Benefits Program (FEHBP), MCHA, a medical care program of the Indian Health Service or of a tribal organization, a high-risk pool in any state, a public health plan, and a health benefit plan under Section 5(e) of the Peace Corps Act.						
Eligibility Questionnaire							

Applicant Name: _____

11. Please attach two (2) rejections from within the last six months, or if you have any of the medical conditions listed on page 2, please name the condition in the space provided below and **attach proof of the medical condition** (e.g., claim with stated diagnosis).

If you suffer from any of the specific conditions listed here, you may obtain coverage under the plan without having to submit the rejection notices otherwise required.

Medical Conditions

- | | | |
|--|---|---------------------------------------|
| Acquired Immune Deficiency Syndrome (AIDS) | COPD/Emphysema | Malignant Tumor (list specific tumor) |
| Alcoholism within the past 5 years | Coronary Artery Disease | Metastatic Cancer (within 12 years) |
| Alzheimer's Disease | By-Pass Surgery | Morbid Obesity |
| Amyloidosis | Angioplasty | Multiple Sclerosis |
| Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) | Myocardial Infarction | Muscular Dystrophy |
| Anorexia | Crohn's Disease | Myasthenia Gravis |
| Aortic Aneurysm | Cystemegaloriosis | Neurofibromatosis |
| Aplastic Anemia | Cystic Fibrosis | Osteogenesis Imperfecta |
| Ascites | Diabetes Type I | Pacemaker |
| Autism | Diabetes Type II | Peutz-Jeghers Syndrome |
| Banti's Disease | Down's Syndrome | Polycystic Kidney Disease |
| Berger's Disease | Fanconi's Syndrome | Primary Pulmonary Hypertension |
| Bulimia within the past 5 years | Hansen's Disease (Leprosy) | Psychotic Disorders |
| Cardiac Asthma | Heart Valve Replacement (planned or history of) | Rheumatoid Arthritis |
| Cardiomegaly | Hemochromatosis | Sarcoidosis |
| Cardiomyopathy | Hemophilia (A, B, or C) | Stroke |
| Cerebral Palsy | Hepatitis C | Tabes Dorsalis (Locomotor Ataxia) |
| Charcot-Marie-Tooth | History of Major Organ Transplant | Tetralogy of Fallot |
| Chemical Dependency within the past 5 years | HIV Positive | TIAs (Transient Ischemic Attack) |
| Chronic Pancreatitis | Huntington's Chorea | Tuberculosis |
| Chronic Renal Failure | Hydrocephalus | Ulcerative Colitis |
| Cirrhosis of the Liver | Hypogammaglobulinemia | Von Willebrand's Disease |
| Congestive Heart Failure | Leukemia (within 12 years) | Wegener's Granulomatosis |
| | Lupus Erythematosus Systemic | Wilson's Disease |

Conditions of Enrollment

I certify that my answers and statements are true and complete to the best of my knowledge. I certify that, within the last six months, a) I have been rejected or offered a restrictive rider for other health insurance coverage by two insurers, societies, or health service corporations due to reasons of health; or b) I currently have a policy with such restrictive rider and have been rejected two times for other coverage in the past six months; or c) I have a medical condition listed above.

For the federal MAC plan, I certify that I have not had comprehensive health coverage for the past six months.

I certify that I am not eligible for any other individual or group comprehensive health insurance coverage (not applicable to the MAC Plan). I additionally certify that neither my employer nor my spouse's employer is paying my MCHA health insurance premiums and that no employer will be reimbursing me for premiums that I pay to MCHA.

I understand that an intentional material misrepresentation or fraudulent misstatement on this application may result in loss of coverage. I understand that a person who submits an application or files a claim with the intent to defraud or helps commit a fraud against an insurer or health plan may be guilty of a crime under Montana Code 33-1, Part 12. **I enclose payment for one month's premium.**

For the MAC Plan, I understand that if I cease to meet the eligibility requirements for this plan, e.g., obtain other group coverage or am no longer a Montana resident, I am responsible to notify the lead carrier of the change and my MCHA coverage will end.

For all other plans, I understand that if I cease to meet the eligibility requirements for this plan, e.g., obtain or become eligible for other group coverage or am no longer a Montana resident, I am responsible to notify the lead carrier of the change and my MCHA coverage will end.

I certify that I have read the questions on page 3 that are designated "For Producer's Use Only" and I understand and agree to these questions.

Enrollment in the federal MAC plan is limited and on a first-come basis. The federal MAC plan is funded by the federal government. I understand that after the funding is exhausted, I will have the option to move to an MCHA traditional plan of my choice and I will be required to pay the regular MCHA premium.

Signature of Applicant
DO NOT PRINT

Signature Date
mo / day / yr

_____/_____/_____

Applicant Name: _____

PLEASE TYPE OR PRINT IN BLACK INK

IMPORTANT

This electronic funds transfer (EFT) authorization section needs to be completed only if this is the payment method you have selected.

To _____, Montana.
(Name and City of Your Bank)

You are hereby authorized to honor Electronic Funds Transfer (EFT) drawn by Montana Comprehensive Health Association on my account in payment of Montana Comprehensive Health Association dues at the prevailing rate. This authorization is to remain in force until revoked by me in writing through the Office of Montana Comprehensive Health Association, Helena, Montana.

Electronic Funds Transfer (EFT) Authorization

Date
(mo / day / yr)

Subscriber ID

/ /

Type of Account

Account Number

Checking Account Savings Account

PRINT Account Owner's Name

Account Owner's Signature
DO NOT PRINT

***** ATTACH A DEPOSIT SLIP OR A VOIDED CHECK *****

Montana Comprehensive Health Association agrees to pay to any bank or banker all sums of money, which said bank or banker shall become legally obligated to pay because of any deduction of money for Montana Comprehensive Health Association as herein authorized by the bank customer whose signature appears above.

Producer's Use Only

- 1. Have you advised the Applicant to read, complete, and sign this Application Form to the best of his or her ability? Yes No
- 2. Have you advised the Applicant that coverage will not commence until he or she is notified that his or her Application has been received and has been accepted by the MCHA? Yes No
- 3. Have you advised the Applicant that if his or her Application contains any intentional misrepresentation of his or her information, coverage may be subject to rejection or termination? Yes No
- 4. Have you explained the preexisting condition limitation to the Applicant? (Does not apply to the federal MAC Plan) Yes No
- 5. Do you certify that neither you nor, to your knowledge, anyone else has referred this Applicant to the MCHA Plan in order to separate the Applicant from a group health insurance contract obtained with the Applicant's employment? Yes No

Name

Address

City

State

ZIP Code

Disability Insurance State License Number

Tax ID Number

Telephone Number

Signature

Date

BCBSMT Agent
Number (if applicable)

Lead Carrier Use Only

Group No. _____ Effective Date _____ Package Number _____

Approved

Date

Rejected

Date



Administered by
Blue Cross and Blue Shield of Montana
P.O. Box 4309
Helena, MT 59604-4309
1-800-447-7828, Extension 2128