Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

Individual/Family Health Insurance
HEALTH ADVANTAGE APPLICATION

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. THE APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- **Must be submitted electronically. PDF for recording data only.**
- **Agents are required to keep this application for 10 years.**

NOTE: Additional documentation required should be faxed to Health Advantage at 501-378-3752 or emailed to **crmcustomerserviceHA@healthadvantage-hmo.com** immediately following the submission of the application.

Health Advantage

APPLICATION FOR HEALTH INSURANCE

SECTION 1 | WHO IS APPLYING?

- The subscriber (the owner of the evidence of coverage) should be listed on the first line of the application. If applicant is under the age of 18, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant who is a U.S. Citizen. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 18 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 18 or older.
- In "Relationship" box, indicate "spouse, son, daughter, stepson, stepdaughter or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (e.g., legal guardianship) when submitting the application.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.
				Self			

SECTION 2 | PARENT/GUARDIAN (If evidence of coverage is only for a child under age 18)

- If applicant is under the age of 18, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 18, please submit appropriate dependent documentation (e.g., legal guardianship) when submitting the application.

First Name	M.I.	Last Name	Relationship **(Check One)**
			❑ Mother ❑ Stepmother ❑ Guardian ❑ Father ❑ Stepfather

SECTION 3 | MARITAL STATUS

❑ Single (including widowed or divorced) ❑ Married (including separated)

SECTION 4 | U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or Green Card issued by the U.S. Citizenship and Immigrant Services may be requested.
- A person must be lawfully present in the U.S. for the entire period of enrollment.

❑ Yes ❑ No Are all applicants U.S. citizens? If "no," please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name: ______________________________

Name: ______________________________

OFFICE USE ONLY (Do not write in this space)

I.D. No.	Group No.	Effective Date

(Continued on page 2)

SECTION 5 | RESIDENTIAL ADDRESS (Must be permanent address – No P.O. box, please)

Street ______ City ______ State ______ Zip ______ County ______

SECTION 6 | MAILING ADDRESS (Complete only if different from residential address)

Street or P.O. Box ______ City ______ State ______ Zip ______

SECTION 7 | BILLING (Complete only if different from residential address)

Street or P.O. Box ______ City ______ State ______ Zip ______

SECTION 8 | CONTACT INFORMATION*

Primary Phone Number	Alternate Phone Number
( )	( )

How do you prefer we communicate with you? ❑ E-mail ❑ Phone

*Health Advantage may contact you, either directly or through a business associate, using your postal or email addresses, telephone numbers or other personal information, regarding your health insurance plan, healthcare providers participating in our networks, disease management, health education and health promotion, preventive care options, wellness programs, treatment or care coordination or case management activities of Arkansas Blue Cross and Blue Shield or Health Advantage.

SECTION 9 | HOUSEHOLD INFORMATION

❑ Yes ❑ No Are all applicants permanent, legal residents of Arkansas?
If "no," please provide reason and his/her name and address:

Name: ______ Address: ______

Reason: ______

Name: ______ Address: ______

Reason: ______

SECTION 10 | CURRENT/PREVIOUS INSURANCE COVERAGE

❑ Yes ❑ No a. Will the coverage applied for replace or change current hospital, medical or major medical insurance if this coverage is approved and accepted by the applicant?

i. If "yes," please provide name and phone number of carrier:
(___) ______

ii. If "yes," does the coverage have a specified termination date? If so, please provide date: ___ /____ /____

iii. Is this coverage ending due to nonpayment of premiums? ❑ Yes ❑ No

iv. If "yes," and the coverage does not have a specified termination date, will the coverage terminate if approved and accepted by the applicant? ❑ Yes ❑ No

v. Is this a limited benefit plan like a short-term or accident policy? ❑ Yes ❑ No

❑ Yes ❑ No b. Have any applicants recently lost employer-sponsored health coverage?* If "yes," please provide:

Name:______ Carrier Name:______ Termination Date:___ /____ /___

Name:______ Carrier Name:______ Termination Date:___ /____ /___

❑ Yes ❑ No c. Have any applicants recently "involuntarily" lost other health coverage?* If "yes," please provide:

Name:______ Carrier Name:______ Termination Date:___ /____ /___

Name:______ Carrier Name:______ Termination Date:___ /____ /___

❑ Yes ❑ No d. Will any applicants be **continuing** any other health insurance? If "yes," please provide:

Name:______ Carrier Name:______ ID # ______

Name:______ Carrier Name:______ ID # ______

 (Continued on page 3)

SECTION 10 (continued) | CURRENT/PREVIOUS INSURANCE COVERAGE

❑ Yes ❑ No e. Are any applicants covered by Medicaid (including AR Kids First)? If "yes," please provide name(s) below:

Name:____

Name:____

❑ Yes ❑ No f. Are any applicants covered by or eligible for Medicare Part A or Part B or Medicare Advantage (Part C)? If "yes,"please provide name(s) below:

Name:____

Name:____

*When your current policy ends, you may be given a Certificate of Creditable Coverage (COCC). A COCC is issued by your previous health insurance company and provides proof of prior coverage. Once you receive a COCC, please provide us a copy.

SECTION 11 | POLICY ELIGIBILITY

Check all applicable boxes below that support your eligibility to apply for this policy and – if applicable – provide date of qualifying life event.

	Date		Date		Date
❑ 1–Annual Open Enrollment Period:	11/1 – 12/15	❑ 8–Loss of Minimum Essential Coverage	________	❑ 11–Errors, misinterpretation, in action by the Exchange, HHS, or their agents	________
❑ 2–Birth	________	❑ 9–Non-calendar Year Policy expires outside OEP (This is a one-time SEP, which will be used for those losing coverage due to the expiration of a non-grandfathered policy.)	________	❑ 12–QHP Contract Violation in relation to an individual	________
❑ 3–Adoption	________			❑ 13–Loss of eligibility for APTC	________
❑ 4–Death	________			❑ 14–Same sex marriage	________
❑ 5–Marriage	________			❑ 15–Eligible for other coverage	________
❑ 6–Divorce or Legal Separation	________			❑ 16–Other (Give specific details and date)________	________
❑ 7–New Guardianship/ Legal Custody/ Court Order to add child	________	❑ 10–New coverage becoming available as a result of a permanent move	________		

NOTE: If application is **not** received during the Open Enrollment Period, we must receive appropriate documentation with this application to confirm qualifying life event/special election period (i.e. copy of marriage license, Certificate of Creditable Coverage from previous insurance company, legal guardianship/custody documentation, etc.) no greater than 60 days before triggering event and no later than 60 days after triggering event, except in the case of birth where the application must be received no later than 90 days after birth. Birth certificate required **only** if newborn (child 0-90 days old, as of received date) is not applying for coverage.

SECTION 12 | TOBACCO USAGE

❑ Yes ❑ No Does any enrollee that will be covered currently use any form of tobacco?

Name: ____

SECTION 13 | PRIMARY CARE PHYSICIAN(S) (Please list for each applicant)

Applicant	PCP First Name	PCP Last Name	PCP City	PCP State	PCP Zip

SECTION 14 | PLAN SELECTION

MUST CHOOSE ONE BOX ONLY

HA GOLD PLAN

❑ HSA 1

HA SILVER PLAN

❑ AW1

 (Continued on page 4)

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) The agent or broker involved in this health coverage transaction may receive compensation from HMO Partner's d/b/a Health Advantage (hereafter referred to as Health Advantage), or one of its affiliates, for services related to the placement of this health care coverage. Any such compensation is included in the premium paid by the subscriber. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (2) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (3) Health Advantage may phone me for additional information that may help with the timely processing of my application.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that if intentionally fraudulent misstatements were made, Health Advantage may take legal action at any time; (c) understand my signature authorizes Health Advantage to coordinate benefits under this evidence of coverage with other coverage I have which is subject to coordination; (d) agree that this application shall be valid without time limit; (e) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request. I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

This contract does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. The coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact Health Advantage or your agent if you wish to purchase pediatric dental coverage or a stand-alone services product.

Rates are based on where you and any covered dependents live in Arkansas and tobacco use.

Health Advantage does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

SIGNATURE SECTION | (Please sign appropriate line only)

Primary Applicant **OR** Parent Legal/Guardian **(if policy for a minor)**	(Please Sign) **X**	Date Signed

(Continued on page 5)

This section to be completed by sales representative

❑ Yes ❑ No To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Health Advantage and accepted by the applicant?

Sales Rep License or NPN (required)	Sales Representative's Name (Please Print) X	Telephone No.
Agency Federal Tax ID No. Date Signed (If applicable)	Sales Representative's Signature X	Date Signed
Comments:		**OFFICE USE ONLY**

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

FAIR CREDIT REPORTING ACT NOTICE – NOTICE TO PROPOSED INSURED

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Health Advantage.

Your written request should be forwarded to: Health Advantage
Individual Underwriting Division ▪ P.O. Box 2181
Little Rock, Arkansas 72203-2181

POLICY EFFECTIVE DATE

Applications received and approved as a result of Open Enrollment (November 1 through December 15) will have an effective date of January 1 of the following year. Applications received and approved as a result of a life event will have an effective date based on the received date of the application and the life event/eligibility reason. Some exceptions apply. Coverage becomes effective upon the date of the evidence of coverage and is contingent upon receipt of premium.

REMINDERS

To ensure your application is processed as quickly as possible, make sure:

- All questions are answered.
- All the pages are returned.
- All appropriate signatures and signature dates are provided.

Important Note: Depending on the date your application is approved, we may not be able to draft your first premium payment. To ensure coverage, please promptly pay any invoice you receive.

P.O. Box 2181, Little Rock, AR 72203-2181
healthadvantage-hmo.com