



## Traditional Plan Application

\*Applications must be submitted within 30 days after losing prior coverage. 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.

Plan	Deductible	Coinsurance	Maximum Annual Liability
<b>Option I – Indemnity Plan 1000</b>	<b>\$1,000</b>	<b>80/20</b>	<b>\$5,000</b>
<b>Option II – PPO 1000</b>	<b>\$1,000</b>	<b>80/20 – 60/40</b>	<b>\$5,000</b>
<b>Option III – PPO 2500</b>	<b>\$2,500</b>	<b>80/20 – 60/40</b>	<b>\$6,750</b>
<b>Option IV – PPO 5000</b>	<b>\$5,000</b>	<b>80/20 – 60/40</b>	<b>\$9,500</b>
<b>Option V – PPO 7500</b>	<b>\$7,500</b>	<b>80/20 – 60/40</b>	<b>\$12,250</b>
<b>Option VI – PPO 10000</b>	<b>\$10,000</b>	<b>80/20 – 60/40</b>	<b>\$15,000</b>
<b>Option VII – Medicare Carveout PPO</b>	<b>\$1,000</b>	<b>80/20 – 60/40</b>	<b>\$5,000</b>
<b>Premium Assistance PPO 1000</b>	<b>\$1,000</b>	<b>80/20 – 60/40</b>	<b>\$5,000</b>
<b>Premium Assistance Medicare Carveout PPO 1000</b>	<b>\$1,000</b>	<b>80/20 – 60/40</b>	<b>\$5,000</b>

Administered by  
Blue Cross and Blue Shield of Montana  
560 North Park Avenue  
P.O. Box 4309  
Helena, MT 59604-4309

## APPLICATION FOR MCHA COVERAGE

Incomplete information may delay the processing of your application.

PLEASE TYPE OR PRINT IN BLACK INK

<b>Applicant Information</b>	<b>Social Security Number (SSN)</b> <small>Note: Your SSN may be used in your subscriber identification number.</small>			<b>Date of Birth</b> (mo / day / yr) /       /		<input type="checkbox"/> Male <input type="checkbox"/> Female		
	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	
<b>Traditional Plan Options</b>	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"/> Option III – PPO 2500 <input type="checkbox"/> Option VI – PPO 10000                     (Options I – VII may have a 12-month preexisting condition exclusion.) <b>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.</b> (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>							
	_____							
<b>Eligibility Questionnaire</b>	1. Are you a resident of Montana? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for how long?       Years _____ Months _____							
	2. 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.							
	3. 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							
	4. Are you eligible for Medicaid coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	5. 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. <input type="checkbox"/> Yes <input type="checkbox"/> No 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 _____							
	6. 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.							
	7. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, 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 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.							
	8. 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.							
	9. 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).							

Applicant Name: \_\_\_\_\_

Medical Conditions	<p>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.</p>		
	<p>Acquired Immune Deficiency Syndrome (AIDS)          Alcoholism within the past 5 years          Alzheimer's Disease          Amyloidosis          Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)          Anorexia          Aortic Aneurysm          Aplastic Anemia          Ascites          Autism          Banti's Disease          Berger's Disease          Bulimia within the past 5 years          Cardiac Asthma          Cardiomegaly          Cardiomyopathy          Cerebral Palsy          Charcot-Marie-Tooth          Chemical Dependency within the past 5 years          Chronic Pancreatitis          Chronic Renal Failure          Cirrhosis of the Liver          Congestive Heart Failure</p>	<p>COPD/Emphysema          Coronary Artery Disease          By-Pass Surgery          Angioplasty          Myocardial Infarction          Crohn's Disease          Cystemegaloriosis          Cystic Fibrosis          Diabetes Type I          Diabetes Type II          Down's Syndrome          Fanconi's Syndrome          Hansen's Disease (Leprosy)          Heart Valve Replacement (planned or history of)          Hemochromotosis          Hemophilia (A, B, or C)          Hepatitis C          History of Major Organ Transplant          HIV Positive          Huntington's Chorea          Hydrocephalus          Hypogammaglobulinemia          Leukemia (within 12 years)          Lupus Erythematosus Systemic</p>	<p>Malignant Tumor (list specific tumor)          Metastatic Cancer (within 12 years)          Morbid Obesity          Multiple Sclerosis          Muscular Dystrophy          Myasthenia Gravis          Neurofibromatosis          Osteogenesis Imperfecta          Pacemaker          Peutz-Jeghers Syndrome          Polycystic Kidney Disease          Primary Pulmonary Hypertension          Psychotic Disorders          Rheumatoid Arthritis          Sarcoidosis          Stroke          Tabes Dorsalis (Locomotor Ataxia)          Tetralogy of Fallot          TIAs (Transient Ischemic Attack)          Tuberculosis          Ulcerative Colitis          Von Willebrand's Disease          Wegener's Granulomatosis          Wilson's Disease</p>
Conditions of Enrollment	<p>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.</p> <p>I certify that I am not eligible for any other individual or group comprehensive health insurance coverage. 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.</p> <p>I understand that an omission, concealment of facts, incorrect statement, 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 is guilty of a crime under Montana Code 33-1, Part 12. <b>I enclose payment for one month's premium.</b></p> <p>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.</p> <p>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.</p>		
	<p>Signature of Applicant DO NOT PRINT</p>		<p>Signature Date mo / day / yr</p>
<p>_____</p>		<p>____ / ____ / ____</p>	

Applicant Name: \_\_\_\_\_

PLEASE TYPE OR PRINT IN BLACK INK

Electronic Funds Transfer (EFT) Authorization	<b>IMPORTANT</b>				
	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.				
	Date <small>(mo / day / yr)</small>		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 does not contain an accurate record 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?				☐ 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  
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Helena, MT 59604-4309