COMMUNITY HEALTH CHOICE
COMMUNITY CARES.

Applicant Name _____

SSN# _____

Member ID: _____

Effective/Term Date: _____

Individual Plan

New Application or Change in Coverage

You have the option to choose a Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

To help us process your application promptly, please remember to:

1	Print all answers in **blue or black ink**. Pencil will not be accepted.
2	Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line.
3	If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information.
4	Please do not use correction fluid or tape.

Please submit an application via one of the following methods. If submitting by mail or fax, please complete the entire application and select a premium mode in Section D.

If you are working with a Community Health Choice Agent, please remember to include the name of your agent on the back of this application.

APPLY BY MAIL	Community Health Choice - Attn: HIM Enrollment 2636 South Loop West, Ste. 125		
APPLY VIA FAX	713-295-7015	APPLY VIA EMAIL	MarketPlace@CommunityCares.com

If you have any questions, please call your agent at 713-295-6704 or toll-free at 1-855-315-5386 Option 4.

Please answer the following questions only if you are applying outside of the annual open enrollment period.
I am requesting enrollment outside of the Annual Enrollment Period because I have experienced one or more of these events during the last 60 days (check all that apply and supply supporting documentation):

☐ **1.** I GAINED A DEPENDENT DUE TO MARRIAGE ON	DATE
☐ **2.** I GAINED A DEPENDENT DUE TO BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION ON	DATE
☐ **3.** I AM NO LONGER ELIGIBLE AS A DEPENDENT UNDER MY PRIOR HEALTH INSURANCE PLAN DUE TO REACHING THE MAXIMUM AGE, LEGAL SEPARATION, DIVORCE, OR DEATH OF THE POLICYHOLDER, AS OF	DATE
☐ **4.** I AM NO LONGER ELIGIBLE FOR MY PRIOR HEALTH INSURANCE PLAN DUE TO TERMINATION OF EMPLOYMENT, REDUCTION IN NUMBER OF HOURS OF EMPLOYMENT, LOSS OF EMPLOYER CONTRIBUTION TOWARD MY PREMIUMS, OR I HAVE EXHAUSTED MY COBRA BENEFITS AS OF	DATE
☐ **5.** I GAINED ACCESS TO NEW HEALTH PLAN OPTIONS BECAUSE OF A PERMANENT MOVE ON	DATE
☐ **6.** I AM NEWLY INELIGIBLE FOR PAYMENTS OF THE ADVANCE PREMIUM TAX CREDIT AS OF	DATE
☐ **7.** I AM NO LONGER RESIDING OR LIVING IN MY PRIOR HEALTH INSURANCE PLAN'S HMO SERVICE AREA AS OF	DATE
☐ **8.** AN ERROR OCCURRED IN MY PREVIOUS HEALTH PLAN ENROLLMENT ON	DATE
☐ **9.** I HAVE ADEQUATELY DEMONSTRATED THAT MY PREVIOUS HEALTH PLAN OR ISSUER SUBSTANTIALLY VIOLATED A MATERIAL PROVISION OF ITS CONTRACT WITH ME, AS OF	DATE
☐ **10.** I AND/OR MY DEPENDENT(S) LOST MINIMUM ESSENTIAL COVERAGE [DUE TO REASONS OTHER THAN NON-PAYMENT OF PREMIUM OR RESCISSION] ON	DATE
☐ **11.** COURT ORDER	DATE
☐ **12.** OTHER QUALIFYING EVENT (AS REQUIRED OR PERMITTED BY APPLICABLE LAWS). PLEASE SPECIFY HERE:	DATE

Section A: Applicant(s)

Applicant Name ______________________

SSN# ______________________

PRIMARY APPLICANT

☐ NEW COVERAGE ☐ ADD DEPENDENT ☐ CHANGE IN COVERAGE ☐ TERMINATE/CANCEL COVERAGE

FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH	STATUS: MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐

ARE YOU A U.S. CITIZEN? Y N
ARE YOU AN ELIGIBLE NON-CITIZEN? Y N

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

DO YOU HAVE A PREFERRED WRITTEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO** (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

RESIDENTIAL ADDRESS - STREET, CITY, STATE, ZIP (NO P.O. BOXES) | **COUNTY**

MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)

PRIMARY PHONE CAN WE SEND YOU TEXT MESSAGES? ☐ | **SECONDARY PHONE** CAN WE SEND YOU TEXT MESSAGES? ☐ | **OTHER PHONE** CAN WE SEND YOU TEXT MESSAGES? ☐

EMAIL ADDRESS | **PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN (FOR HMO ONLY) | **PCP#** (FOR HMO ONLY) | **DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ?** (FOR HMO ONLY) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

OBSTETRICIAN OR GYNECOLOGIST (FOR HMO ONLY) | **OB/GYN#** (FOR HMO ONLY)

SPOUSE AND/OR DEPENDENT CHILDREN TO BE COVERED/TERMED (dependent children must be under age 26)

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

ARE YOU A U.S. CITIZEN? Y N
ARE YOU AN ELIGIBLE NON-CITIZEN? Y N

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO** (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

***MAILING ADDRESS - STREET, CITY, STATE, ZIP** (IF DIFFERENT THAN ABOVE) | **COUNTY**

PRIMARY PHONE CAN WE SEND YOU TEXT MESSAGES? ☐ | **EMAIL ADDRESS** | **PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN (FOR HMO ONLY) | **PCP#** (FOR HMO ONLY) | **DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ?** (FOR HMO ONLY) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

OBSTETRICIAN OR GYNECOLOGIST (FOR HMO ONLY) | **OB/GYN#** (FOR HMO ONLY)

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

ARE YOU A U.S. CITIZEN? Y N
ARE YOU AN ELIGIBLE NON-CITIZEN? Y N

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO** (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

***MAILING ADDRESS - STREET, CITY, STATE, ZIP** (IF DIFFERENT THAN ABOVE) | **COUNTY**

PRIMARY PHONE CAN WE SEND YOU TEXT MESSAGES? ☐ | **EMAIL ADDRESS** | **PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN (FOR HMO ONLY) | **PCP#** (FOR HMO ONLY) | **DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ?** (FOR HMO ONLY) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

OBSTETRICIAN OR GYNECOLOGIST (FOR HMO ONLY) | **OB/GYN#** (FOR HMO ONLY)

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

ARE YOU A U.S. CITIZEN? Y N
ARE YOU AN ELIGIBLE NON-CITIZEN? Y N

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO** (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

***MAILING ADDRESS - STREET, CITY, STATE, ZIP** (IF DIFFERENT THAN ABOVE) | **COUNTY**

PRIMARY PHONE CAN WE SEND YOU TEXT MESSAGES? ☐ | **EMAIL ADDRESS** | **PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN (FOR HMO ONLY) | **PCP#** (FOR HMO ONLY) | **DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ?** (FOR HMO ONLY) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

OBSTETRICIAN OR GYNECOLOGIST (FOR HMO ONLY) | **OB/GYN#** (FOR HMO ONLY)

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

ARE YOU A U.S. CITIZEN? Y N
ARE YOU AN ELIGIBLE NON-CITIZEN? Y N

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO** (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

***MAILING ADDRESS - STREET, CITY, STATE, ZIP** (IF DIFFERENT THAN ABOVE) | **COUNTY**

PRIMARY PHONE CAN WE SEND YOU TEXT MESSAGES? ☐ | **EMAIL ADDRESS** | **PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN (FOR HMO ONLY) | **PCP#** (FOR HMO ONLY) | **DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ?** (FOR HMO ONLY) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

OBSTETRICIAN OR GYNECOLOGIST (FOR HMO ONLY) | **OB/GYN#** (FOR HMO ONLY)

† The designation of spouse shall include domestic partners. If applying for domestic partner coverage, please complete the AFFIDAVIT OF DOMESTIC PARTNERSHIP at chchealth.org and submit with this application.
* Age 18 and over

Section B: Applying for Coverage

Applicant Name _____

SSN# _____

NOTE: Effective dates are available on the 1st of the month only, unless otherwise required by law. Applications must be received by Community Health Choice Inc. within the defined enrollment period to be accepted.

PLAN SELECTION	DEDUCTIBLE
☐ Community Health Choice HMO BRONZE DEDUCTIBLE - 003	$5,000 Individual/$10,000 Family
☐ Community Health Choice HMO SILVER DEDUCTIBLE - 004	$1,500 Individual/$3,000 Family
☐ Community Health Choice HMO GOLD DEDUCTIBLE - 005	$500 Individual/$1,000 Family
PLAN SELECTION	**COPAY**
☐ Community Health Choice HMO SILVER COPAY - 002	$40 PCP/$75 Specialist
☐ Community Health Choice HMO GOLD COPAY - 001	$30 PCP/$65 Specialist
PLAN SELECTION	**COPAY**
☐ KelseyCare powered by Community Health Choice HMO SILVER COPAY - 007	$40 PCP/$75 Specialist
☐ KelseyCare powered by Community Health Choice HMO GOLD COPAY - 006	$30 PCP/$65 Specialist

For HMO Only:

ATTENTION FEMALE MEMBERS: In selecting your PCP, remember that your PCP's network may affect your choice of OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your PCP.

Section C: Billing Information

Applicant Name _____

SSN# _____

Note: Do not cancel any current coverage you may have until your application is approved and your new plan is effective.
Please select one of the following options to make arrangements for paying your premium.

☐ Bank Draft

Bank Draft includes initial and ongoing payments. Payment will be drafted upon receipt of this application. You must complete the Authorization Agreement below.

☐ FIRST MONTH'S PREMIUM ☐ RECURRING MONTHLY ☐ 15th ☐ 25th RECURRING DRAFT DATE

AUTHORIZATION AGREEMENT

Required for Bank Draft Payments Only
I request and authorize Community Health Choice and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer–sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium, or provide reimbursement for any part of the premium now or in the future. I also understand that both the financial institution and reserve the right to terminate this payment program and/or my participation therein. To make changes to my financial institution I understand that I will need to provide at least 10 days advance notice to Community Health Choice by telephone prior to a scheduled withdrawal date. I understand I am responsible for ensuring the payment is processed successfully.

Please complete the following – print or type information
I authorize Community Health Choice to deduct the premium payments from my checking or savings account. If the draft date falls on a non–business day or a holiday, the premium payment will be deducted from my account on the next business day.

Please ensure adequate funds are available at the time of application. Community Health Choice is not responsible for fees incurred due to insufficient funds.

PLEASE CHECK ONE ☐ CHECKING ACCOUNT ☐ SAVINGS ACCOUNT	NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT	COPY OF VOIDED CHECK ATTACHED: ☐

NAME AND LOCATION OF BANK WHERE ACCOUNT IS AUTHORIZED

BANK TRANSIT NUMBER	DEPOSITOR'S ACCOUNT NUMBER

☐ I HAVE READ AND ACCEPT THE ABOVE AGREEMENT

DEPOSITOR'S SIGNATURE	DATE	RELATIONSHIP TO APPLICANT

☐ Credit Card (Visa, MasterCard, Discover)

Credit Card includes initial and ongoing payments. Payment will be drafted upon receipt of this application. You must complete the Authorization Agreement below.

☐ FIRST MONTH'S PREMIUM ☐ RECURRING MONTHLY ☐ 15th ☐ 25th RECURRING DRAFT DATE

AUTHORIZATION AGREEMENT

Required for Bank Draft Payments Only
I request and authorize Community Health Choice and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer–sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium, or provide reimbursement for any part of the premium now or in the future. I also understand that both the financial institution and reserve the right to terminate this payment program and/or my participation therein. To make changes to my financial institution I understand that I will need to provide at least 10 days advance notice to Community Health Choice by telephone prior to a scheduled withdrawal date. I understand I am responsible for ensuring the payment is processed successfully.

Please complete the following – print or type information
I authorize Community Health Choice to deduct the premium payments from my checking or savings account. If the draft date falls on a non–business day or a holiday, the premium payment will be deducted from my account on the next business day.

Please ensure adequate funds are available at the time of application. Community Health Choice is not responsible for fees incurred due to insufficient funds.

FIRST NAME ON CREDIT CARD (EXACTLY AS PRINTED)

BILLING ADDRESS FOR CREDIT CARD (STREET, APT. #)	CITY STATE, ZIP	
CREDIT CARD NUMBER	EXPIRATION DATE	CVV CODE
SIGNATURE	TODAY'S DATE	

Bill all charges to the above card(s). Since the payment amount may vary, I will receive written notification of the amount and date of the next charge prior to each scheduled transaction date. This authorization is valid until I provide you with written cancellation or verbal.

☐ CHECKING ACCOUNT

☐ MONTHLY BY CHECK ☐ FIRST MONTH PREMIUM AMOUNT OF $ ☐ ENCLOSED ☐ Y ☐ N

MAKE CHECKS PAYABLE AND MAIL TO:

Community Health Choice, Inc.
PO Box 844124
Dallas, TX 75284-4124

*Must include subscriber number

NOTE: Cashing of the Premium Deposit does not constitute approval of this Application. If this Application is not approved, the Premium Deposit will be returned to the Primary Applicant and neither the Primary Applicant nor any other person applying for coverage under this Application shall be entitled to benefits or coverage.

BILLING NAME AND ADDRESS

If different than applicant name and residential address. If an address is entered in this section, only the billing will be sent to this address; all other correspondence will be sent to the address in Section A, unless requested otherwise.

FIRST NAME, MIDDLE INITIAL, LAST NAME

BILLING ADDRESS - STREET, CITY STATE, ZIP (NO P.O. BOXES)

NAME OF BILL-TO PARTY (IF REQUESTING LIST BILL ONLY)

Section D: Other Coverage Information

Applicant Name _____

SSN# _____

OTHER COVERAGE INFORMATION

DOES ANY PERSON APPLYING FOR COVERAGE CURRENTLY HAVE HEALTH OR MAJOR MEDICAL COVERAGE WITH ANY OTHER INSURER, EITHER AS A PRIMARY INSURED, SPOUSE OR AS A DEPENDENT?
[Y] [N] **IF "YES", PLEASE COMPLETE THE FOLLOWING:**

APPLICANT NAME	NAME ON PREVIOUS POLICY (IF APPLICABLE)	MEMBER/GROUP NUMBER (OPTIONAL)
APPLICANT NAME	**NAME ON PREVIOUS POLICY (IF APPLICABLE)**	**MEMBER/GROUP NUMBER (OPTIONAL)**

REPLACEMENT OF COVERAGE

WILL THIS COVERAGE REPLACE ANY HEALTH COVERAGE CURRENTLY IN FORCE? [Y] [N] **IF "YES," READ THE STATE MENT BELOW AND COMPLETE THE FOLLOWING:**

LIST ALL COVERAGE THAT WILL BE REPLACED

INSURED	NAME OF COMPANY	POLICY NUMBER	TERMINATION DATE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS COVERAGE

If "Yes" is indicated above, you intend to lapse or otherwise terminate existing accident and sickness coverage and replace it with a contract to be issued by Community Health Choice. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the coverage protection available to you under the new contract.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning any person applying for coverage. Failure to include all material information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
3. It is recommended that you not terminate your present contract until you are certain that your application for the new contract has been accepted by Community Health Choice.

Section E: Required Signatures

Acknowledgements: The Applicant, to the best of his/her knowledge and belief, represents and agrees as follows:

1. This application does not provide coverage of any kind unless approval is provided by Community Health Choice (the Company); and the application, if not previously approved or declined, will be considered withdrawn on the 60th day after its date.
2. Medical expense coverage will not be available until the effective date of the health contract and payment, in full, of the first month's premium.
3. No agent can accept risks or modify policies or requirements of the Company.
4. The Company is not bound by any statement not written in this application.
5. If a spouse and/or dependant(s) is/are included for medical expense coverage, the premium will be calculated based on the age of each individual covered, subject to applicable law and regulations.
6. I understand that an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on this application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. I will be provided with at least 30 days' advance written notice before my or my dependent's coverage may be rescinded, retroactive to the effective date of coverage. The undersigned Applicant further acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an Individual Policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such Individual Policy. The undersigned further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid the agent by the Company in connection with the issuance of the Individual Policy, they should contact the agent.

Agreement: I understand that any statements and answers on this application are representations. To the best of my knowledge and belief they are true and complete. These representations are the basis of my application. I understand that coverage will be effective following payment in full of the first month's premium. The undersigned Applicant and agent acknowledge that the Applicant has read the completed application and that he/she realizes that any false statement material to the risk or misrepresentations therein may result in loss of coverage under the policy. This application will become a part of the contract between and the applicant.

Authorization: I authorize any medical professional, hospital, clinic or other medical or medically related facility, governmental agency, pharmacy benefit manager, retail pharmacy, pharmacy clearinghouse or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including and without limitation, information relating to the prescription and use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information. I understand that Community Health Choice will only disclose collected information as needed to medical entities related to my care.

I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and will no longer protected by the federal privacy laws.

This Authorization is valid for two years from today, or until I terminate coverage. I understand that I have the right to revoke the Authorization at any time, in writing, by contacting Community Health Choice I further understand that I or any authorized representative will receive a copy of this authorization upon request. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

Signatures: I acknowledge receipt of the Required Outline of Coverage and I certify that:

1. Premiums are being paid by me as a personal expense.
2. My employer is not contributing to any part of the premium, either directly or through reimbursement.
3. Since my employer does not sponsor an employee health plan, neither my employer nor I deduct any part of the premiums from gross income under section 106 or section 162 of the Internal Revenue Code.

The Disclosure Statement will be provided upon request. (Also available at ?)

At any time when Communith Health Choice is entitled to rescind coverage already in force, or is otherwise permitted to make retroactive changes to this Policy, Community Health Choice may at its option make an offer to reform the policy already in force and/or change the rating category/level. In the event of reformation, the Policy will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application.

PRIMARY APPLICANT'S SIGNATURE	**DATE**
SPOUSE'S SIGNATURE (IF APPLYING)†	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**

IF THIS AUTHORIZATION IS SIGNED BY A PERSONAL REPRESENTATIVE, ON BEHALF OF AN INDIVIDUAL (OTHER THAN A PARENT FOR A MINOR CHILD), COMPLETE THE FOLLOWING:

PERSONAL REPRESENTATIVE'S NAME (PLEASE PRINT)	**RELATIONSHIP:**

† The designation of spouse shall include domestic partners. If applying for domestic partner coverage, please complete the AFFIDAVIT OF DOMESTIC PARTNERSHIP and submit with this application.

Section F : Agent Information

Applicant Name _____

SSN# _____

AGENT'S CERTIFICATION
Agent's Certification: I certify that I sent the application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this application and that written material explaining the benefits, exclusions, and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the Required Outline of Coverage, and if requested, the Disclosure Statement.
POLICY(IES) SHOULD BE MAILED TO ☐ AGENT ☐ APPLICANT

AGENT INFORMATION (if applicable)			
AGENT'S SIGNATURE	**DATE**	**AGENT ID / NPN NUMBER**	
PRINT AGENT'S NAME	**AGENT'S PHONE**		**AGENT'S FAX**

Section G: HMO Disclosure

Texas Department of Insurance Required Disclosure Notice for All **Individual HMO** Consumer Choice Benefit Plans Issued in Texas

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Health Benefit Plan that I am purchasing does not include all state mandated health insurance benefits. I understand that the following benefits are provided at a reduced level from what is mandated, or excluded completely from the plan.

MANDATED BENEFIT DESCRIPTION	BENEFIT REDUCED	BENEFIT EXCLUDED
An HMO can only charge a deductible for services rendered outside of the HMO's service area or out-of-network.	Community Health Choice will utilize a deductible for most services.	

I also understand that if I purchase a health plan that excludes or reduces coverage for a certain condition, I may be limiting my ability to obtain individual insurance coverage for that condition, in the event the health of any individual covered under the plan changes. I understand that I may obtain addition information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.texas.gov/consumer/index.html, or by calling 1-800-252-3439.

SIGNATURE OF APPLICANT	**NAME OF APPLICANT (PRINT NAME)**	**DATE**
BILLING ADDRESS - STREET, CITY STATE, ZIP (NO P.O. BOXES)		

Note: This form must be retained by the carrier issuing the policy and must be provided to the Commissioner of Insurance upon request. **You have the right to a copy of this written disclosure free of charge.** A new form must be completed upon each subsequent renewal of this policy.

Thank you for applying.

Please include all necessary materials when submitting this application.
If legal guardian, please enclose signed court decree.

Community Health Choice Inc.