CHAMBERCARE

CHAMBERCARE APPLICATION
EMPLOYEE APPLICATION

Please return signed application by:
(1) mail to ChamberCare PO Box 388 Columbus, IN 47202-0388 Attn: Membership;
(2) email to Eligibility@ChamberCare.org

This application must be used for new enrollments for ChamberCare groups with 2-50 employees.

1. REASON FOR APPLICATION

This form is completed in order to officially:

☐ Apply as New Enrollee **EFFECTIVE DATE:** Month _____ Day_____ Year_____

I am a: ☐ New Employee ☐ Current Employee ☐ Special Enrollee ☐ Open Enrollment (please mark all that apply)

New and Special Enrollees: identify the qualifying life event (QLE)?
☐ Involuntary Loss of Coverage (*not* failure to pay premium) ☐ Divorce ☐ Other: _____
Date of QLE: __/__/ _____
NOTE: If enrolling due to a QLE, proof of QLE (divorce decree, Certificate of Creditable Coverage, Medicaid, etc.) **must** accompany application.

2. PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Email Address _____ (See back for details on use of email address)

SSN #_____Home Phone _____ Work Phone_____

Birth Date_____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employer_____ Location_____ Job Title _____

Date of Full Time Hire ___/___/___ Date of Rehire ___/___/___ **Avg. Hours Worked:** ☐ 30+ hrs./wk.

Explanation of Benefit (EOB) notification preference: ☐ Member Portal ☐ Email ☐ Mail ☐ Apply to all under 18 dependents

3. CHAMBERCARE PLAN SELECTION

Note: Please see your employer if you are unsure about the plan option(s) available to you.

Health Plan Products (Circle One): PPO High Deductible (HSA)	Deductible Amounts: _____ _____	Coverage Tier: _____ _____
Dental Products (If Offered): Dental	Plan Code: _____	Coverage Tier: _____
Vision Products (If Offered): Vision	Plan Code: _____	Coverage Tier: _____

Coverage Tier:
Employee Only – E
Employee & Spouse – ES
Employee & Children – EC
Employee & Family - F

	Last Name	First Name	Social Security #	Birth Date	Sex F/M
Self					
Spouse					
Child					
Child					
Child					
Child					
Child					

4. OTHER HEALTH INSURANCE COVERAGE INFORMATION

Are you currently actively at work on a full-time basis? ☐ Yes ☐ No If no, reason:_____

Are you covered under Employer's current Health Plan? ☐ Yes ☐ No

Spouse's name: _____ Birth Date_____

Is your spouse employed? ☐ Yes ☐ No If yes, Employer: _____

Will you or any member of your family be covered under any <u>OTHER</u> medical, dental or vision insurance by divorce decree or any other reason?

☐ Yes ☐ No If "yes" type of coverage ☐ Medical ☐ Dental ☐ Vision

If yes, who will be covered?

☐ 01Self ☐ 02 Spouse ☐ 03 Child ☐ 04 Child ☐ 05 Child ☐ 06 Child ☐ 07 Child ☐ More dependents

<u>NOTE:</u> You *<u>must</u>* notify ChamberCare within 30 days of any changes in eligibility, status, or other insurance coverage.

<u>OTHER</u> Insurance Company Name or Plan (including Medicare Part A, B or both): _____

Applicable only if you or a family member are covered by Other Health Insurance.

Address: _____

Policy # (should be listed on card): _____ Effective Date: _____

5. COMPLETE ONLY IF EMPLOYEE IS DECLINING MEDICAL COVERAGE

If you are choosing **NOT** to enroll, **COMPLETE THIS SECTION**.
If your employer pays 100% of the employee cost of this health care coverage, you must enroll in this Health Plan for the employer to be considered eligible for its chosen coverage options.

WAIVER: This is to acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through the employer. I hereby waive the health coverage offered. I am waiving the health coverage and declining to enroll because: *(form will be incomplete if selection is not marked).*

I am annually enrolled in:

☐ Spousal Coverage

☐ Individual Health Coverage

☐ Other: _____

I have:

☐ Coverage under Another Plan

☐ Medicare, Medicaid, or Medical Supplement Coverage

☐ Other: _____

(if waiving, you MUST check/complete one of the above)

I attest that I was not pressured nor forced by the employer named in Section 2, the writing agent, ChamberCare, or any other third-party who might have a vested interest in my waiving (declining) the above noted coverage. I further realize that any future application for coverage under this plan may require additional limitations, waiting periods, or other applicable terms and conditions of a master group contract that would impact my benefits. I also understand that I may be asked to supply additional statements of health for any future enrollment. I freely and voluntarily waive (decline) the above noted coverage.

SIGN ONLY IF DECLINING COVERAGE

Employee Signature: _____ **Date:** _____

Please make sure Section 1, 2 and 5 are completed if you waive or decline coverage.

6. ENROLLMENT AND AUTHORIZATION OF COVERAGE

I acknowledge that I have read the above statements; or they have been read to me, and that I understand them. I declare and agree that the above answers and responses are, to the best of my knowledge and belief, complete, true, and together with any supplement thereto and with no intent to mislead nor deceive, shall be the basis for any certificate of coverage and group policy issued. I understand and agree that neither the employer nor any agent has the authority to waive a complete response to any question, pass on coverage or insurability for me or the group, make or alter any contract, or waive any of the rights or requirements of ChamberCare. I hereby agree that no coverage will be effective until the date specified by ChamberCare on the certificate of coverage after this enrollment for application has been processed and accepted. I understand that any misrepresentation or omission contained herein provided as a part of the process of confirming eligibility to participate, or that is not otherwise reasonably corrected upon actual or constructive notice to the undersigned or any participant enrolled hereunder and is relied on by ChamberCare may impact, reduce, delay or void not only a future claim, but the actual or prospective acceptance of the overall risk and/or the employees contract within the contestable period if such misrepresentation or omission affects the acceptance or the evaluation of this risk. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization only to the extent that it authorizes the disclosure of health information other than for health plan purposes.

I agree that any benefit payable on my behalf under the ChamberCare Health Plan may be paid directly to the provider of care. I authorize my employer to make the necessary deductions from my pay or any disability or retirement annuity benefits to which I may be entitled under any employer-sponsored group benefit plan in which I am enrolled until this authorization is revoked by me in writing. I understand that I must be actively working and otherwise satisfy any applicable eligibility criteria outlined in the Certificate of Coverage.

Upon signing, I agree to the following terms and conditions for myself and for any eligible dependents if coverage should become effective: I understand that if I (we) make any claim for benefit or dispute any decision relative to a claim of benefit, it will be resolved according to the Certificate of Coverage and any of ChamberCare's relevant policies and/or procedures. In fact, all benefits and coverage for my eligible dependents and myself will be provided in accordance with that Certificate and relevant policies and/or procedures. I agree to abide by the terms and conditions governing membership and the receipt of health services benefits. I understand that I can revoke this authorization only to the extent that it permits the use or disclosure of health information other than for health plan purposes at any time by giving written notice to ChamberCare through the employer. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. If I wish to revoke this authorization, I only need to go back to the requesting entity rather than the data sources and/or providers.

If employer has selected to offer voluntary Group Dental Coverage, it is provided under the Group Dental Insurance Policy insured through Delta Dental under the Policy issued by Delta Dental. Group Vision Coverage is provided by Delta Vision under the Group Vision Policy insured through Delta Dental.

By providing my email address, I consent to receive information about my benefits electronically. These communications may include, but are not limited to, the following: Certificates of Coverage or Evidence of Coverage, grievance and appeal notifications, IRS Form 1095-B, Notice of Privacy Practices, and other legally required notices and documents.

Employee Email Address: _____

I am providing my email address because I, and my enrolled dependents, want to receive information about our benefits electronically. These communications may include Identification (ID) Cards, Certificates of Coverage or Evidence of Coverage, grievances, appeals, and medical determination notifications, Explanation of Benefits, other required notices, and personalized information to help get the most out of the benefits. I will make sure ChamberCare has the most up-to-date email address. I, and my enrolled dependents, understand that we can update our email addresses, change our communication preferences, and request free paper copies of any materials at any time by going to www.ChamberCare.org or calling the Member Services number on my ID Card. I also understand I may withdraw my consent at any time without penalty of fees by contacting Member Services by phone or email.

☐ I do not consent to electronic delivery of the above information and notices.

I understand that unless otherwise required by law, ChamberCare will provide all required regulatory notices via its member and/or employer portal(s) accessed at www.ChamberCare.org. I may also receive a printed copy of regulatory notices upon request.

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, rescission of coverage, denial of claims and confinement in prison.

Unless revoked earlier, this authorization will be valid for as long as I am enrolled in any of my employer's chosen ChamberCare Health Plan coverage options and for at least seven (7) years after the date that my coverage ends to the extent that it is required for health plan purposes.

☐ **I elect to enroll/apply in the above-indicated ChamberCare Health Plan coverage options**

_____ _____

Signature of Proposed Insured Employee or Personal Representative Date

_____

Description of Personal Representative