



Since 1976

## **Minnesota Comprehensive Health Association**

### **Instructions & Application for Individual Coverage**

MCHA Customer Service  
1-866-894-8053  
TTY: 952-992-3190 or toll-free at 1-800-841-6753  
Monday – Friday: 7 a.m. – 6 p.m. CST

MCHA Broker / Agent Service Center  
952-992-2200 or toll-free at 1-800-936-6880  
Monday – Friday: 8 a.m. – 5 p.m. CST

#### **Mail the completed application and applicable premium to:**

Minnesota Comprehensive Health Association/Medica  
Mail Route CW282  
401 Carlson Parkway  
Minnetonka, MN 55305-5387

This application may be completed online at:

[www.mchamn.com](http://www.mchamn.com)

To process your MCHA application you must include:

- A fully completed application;
- All required documentation; and
- Your premium payment

Failure to provide this information will delay the processing of your application or the date your coverage becomes effective.

This is an application for coverage only. The benefits provided by MCHA, as well as the terms, conditions, limitations, and exclusions governing those benefits are contained in the MCHA Policy of Coverage and Minnesota law. This application for individual coverage in no way binds MCHA to provide specific benefits to you, nor does it control the terms, conditions, limitations, or exclusions of benefits if coverage is offered to you.

## Instructions

This application contains Sections A-N. **You must complete all sections identified on the application as “Required Information.”** Incomplete applications will be returned to you for completion and may delay your effective date of coverage. Some areas of the application require you to initial the section, providing proof you have read the information and have provided accurate information.

If you have questions about MCHA, eligibility, health plan options and services available to you, call the MCHA Customer Service telephone number listed on the front cover of this application or refer to the “MCHA Summary of Benefits of the Individual Deductible Plan Options and a Federally Qualified High Deductible Health Plan” brochure.

The following information corresponds with each section on the application.

### **Section A. Plan Option Requested** *(Required Information)*

There are six plan options available. Choose the plan in which you want to enroll.

- \$500 Individual Deductible Plan – Deductible is split between \$400 for medical benefits and \$100 for prescription drug benefits.
- \$1,000 Individual Deductible Plan – Deductible is split between \$800 for medical benefits and \$200 for prescription drug benefits.
- \$2,000 Individual Deductible Plan – Deductible is split between \$1,600 for medical benefits and \$400 for prescription drug benefits.

***Each of the three above plans has a \$3,000 annual out-of-pocket maximum.***

- Federally qualified High Deductible Health Plan (HDHP) - The combined annual deductible and out-of-pocket maximum (for both medical and drugs benefits) is \$3,000 for an individual, and \$6,000 for a family. You are responsible for the establishment and coordination of any associated Health Savings Account (HSA) services.
- \$5,000 Individual Deductible Plan – Deductible is split between \$4,000 for medical benefits and \$1,000 for prescription drug benefits. \$5,000 annual out-of-pocket maximum.
- \$10,000 Individual Deductible Plan – Deductible is split between \$8,000 for medical benefits and \$2,000 for prescription drug benefits. \$10,000 out-of-pocket maximum.

View complete MCHA benefit summary information online at [mchamn.com](http://mchamn.com).

### **Section B. Applicant and Dependent Information** *(Required Information)*

The applicant is the individual applying for MCHA coverage. *Dependent Information* (#15) is required only if you (the applicant) add dependent(s) to your policy at the time of application. Eligible dependents may be added to your policy at the time of application, including: a spouse, unmarried natural or adopted children, a child placed for adoption, a child under legal guardianship, a stepchild, and an unmarried grandchild who resides with applicant. A dependent child is eligible for coverage up to age 25. A dependent cannot be added to the policy at a later date unless the dependent is a newborn, a newly adopted child, or a new spouse. A new spouse must be added to the plan within 30 days from the date of marriage.

### **Section C. Residency** *(Required Information)*

You and dependents (if applying for coverage) must be residents of the State of Minnesota. You (the applicant) must provide proof of residency. The length of residency needed to qualify for coverage differs depending on the eligibility category under which you apply:

- If you apply under section “H. Eligibility Categories” option number 1 (Loss of Group Coverage) or option number 2 (Health Coverage Tax Credit program) you must provide proof of Minnesota residency as of the date you are making application to MCHA.
- If you are applying under section “H. Eligibility Categories” option number 3 (Ineligible for the Federal Medicare Program), option number 4 (Evidence of Rejection), or option number 5 (Presumptive Condition(s)), you must provide proof of Minnesota residency for at least six (6) months prior to the date you are making application to MCHA.

Documents must include the name of the applicant or parent/legal guardian of applicant and current Minnesota mailing address, and must be dated within the last six (6) months.

***Required Documentation-*** Acceptable documents proving Minnesota residency include:

- A copy of your current driver’s license
- Current Minnesota State ID with an issue date within the past 4 years
- A current (within the last six 6 months) utility bill

- A recent voter registration card (if registration occurred within last 6 months)
- If applicant is a child under age 19 or under school age, MCHA will accept school records with the child or parent's/legal guardian's name and address, or a driver's license, utility bill, voter registration from the parent or legal guardian (as listed on the previous page).

MCHA reserves the right to rely upon other documentation, in its discretion, to determine if an applicant satisfies the residency requirement.

**Section D. Tobacco Designation** *(Required Information)*

MCHA has “Standard” (non-Tobacco User) premium rates and “Tobacco User” premium rates. You and your dependent spouse (if applying for coverage) must identify if you have used tobacco, including: smoking cigarettes, cigars, pipe, use chewing tobacco, snuff or have used nicotine chewing gum, the nicotine patch or other prescription or over the counter smoking cessation products within the 12 months immediately preceding the date of the application. You must pay the appropriate premium rate that corresponds to your tobacco-user designation.

**Section E. Employment Status** *(Required Information)*

You are required to identify your employment status or the employment status of the person who is responsible for you if you are a dependent. A dependent includes: a spouse; unmarried child (natural, adopted/child placed for adoption or stepchild) up to the dependent limiting age of 25; unmarried grandchild up to the dependent limiting age of 25 who is dependent upon and resides with a grandparent continuously from birth; or unmarried disabled child who is incapable of self-sustaining employment by reason of developmental disability, mental illness, mental disorder or physical disability.

You are **not eligible** for MCHA coverage if you are an employee and eligible for an employer's health plan, except for enrollment or continued enrollment necessary to cover conditions that are subject to an unexpired pre-existing condition limitation, pre-existing condition exclusion, an exclusionary rider under the employer's health care plan, or if you have met an annual maximum benefit under the employer's health plan. Minnesota law prohibits employers from directing an employee to apply for MCHA if they are eligible for the employer's health care plan. Identified cases are reported to the Minnesota Department of Commerce for appropriate action.

**Section F. Other Health Coverage Information** *(Required Information)*

You are required to provide information on your prior health insurance coverage. You are also required to identify other health insurance coverage you have currently.

Note: MCHA can not issue a policy if you are age 65 or over and eligible for Medicare Part A and Medicare Part B, or under age 65 and enrolled in Medicare Part A and Medicare Part B.

**Section G. Reason for Applying for MCHA** *(Required Information)*

Identify the reason(s) you are applying for MCHA coverage. This information is kept confidential and is not used to determine eligibility.

**Section H. Eligibility** *(Required Information)*

There are five (5) different eligibility categories by which you can apply for MCHA coverage. Review all the eligibility categories **and choose only one (1)**. First, review number “1. Loss of Group Coverage.” If applicable, complete this section and include required documentation. Otherwise, choose an eligibility category from numbers 2-5, check the appropriate boxes, and include required documentation.

*Eligibility:*

**1. Loss of Group Coverage:** Eligibility under this category is governed by the Health Insurance Portability and Accountability Act (HIPAA). You must satisfy all of the following requirements to be eligible under this category:

- You must have maintained creditable coverage for at least 18 months with no lapse in coverage of more than 63 days.
- Your most recent coverage has been provided by a group plan through your or a family member's employer sponsored plan, church plan, governmental plan or another state's high risk pool (must be a 501C (26) or the state's HIPAA alternative mechanism).
- If available, you must have elected and exhausted your health benefits through the Consolidation Omnibus Budget Reconciliation Act of 1985 (COBRA) or other similar State or Federal continuation plan.
- Your prior coverage was not lost because you stopped paying the premiums or because you committed fraud.
- You cannot be eligible or have the option to participate in coverage under any other group health plan offered by your or a family member's employer and are not eligible for Medicare or Medicaid.

Documentation supporting eligibility under this category must include the date COBRA or other State or Federal continuation coverage was exhausted. Document examples include a copy of the Certificate of Creditable Coverage, a HIPAA document, if the document clearly indicates that the coverage was through COBRA or continuation. If the Certificate of Creditable Coverage does not indicate that the COBRA or continuation option was exhausted, additional documentation may be required. For assistance regarding the needed documentation, please contact MCHA Customer Service or the MCHA Broker/Agent Service Center at the telephone numbers printed on the front cover of this application packet. Other documents that collaborate creditable coverage (including explanations of benefits or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage).

*Refer to the application section "H. Eligibility, Eligibility Part I," for specific information regarding the effective date of coverage.*

**2. Health Coverage Tax Credit (HCTC) Program:** Eligibility under this category is governed by the HCTC program. The Department of Labor certifies eligibility for the HCTC program. You may receive benefits through Trade-Adjustment Assistance, Alternative Trade Adjustment Assistance, or the Pension Benefit Guaranty Corporation. You must include a copy of the HCTC candidate letter with your application.

*Refer to the application section "H. Eligibility, Eligibility Part I," for specific information regarding the effective date of coverage.*

**3. Ineligible for the Federal Medicare Program:** You may be eligible under this category if you have reached age 65 or over and are *not* eligible for the health insurance benefits under the Federal Medicare program. You must submit a letter from Social Security stating you are ineligible for Medicare.

*Refer to the application section "H. Eligibility, Eligibility Part I," for specific information regarding the effective date of coverage.*

**4. Evidence of Rejection:** You may be eligible under this category if you have received a rejection of individual health insurance coverage. You must have received a rejection of coverage within six (6) months prior to the date of MCHA application from a:  
a) Minnesota health insurance carrier; or  
b) Minnesota licensed health insurance agent (the agent must complete the "*Agent Certification of Rejection*" information within section "L. Agent Information").

*If you are eligible under this category, the effective date of coverage is the date the application and all required documentation and premium is received by MCHA, or if a preexisting condition limitation waiver is requested and approved, the effective date will be backdated to the day following termination of prior coverage. If you choose a date other than the day after termination of prior coverage, the waiver is relinquished and a six-month pre-existing condition limitation will apply to your policy. Refer to the application section "I. Request for Pre-existing Condition Limitation Waiver."*

**5. Presumptive Condition(s):** If you have been treated for one of the presumptive conditions listed within the application, under section "H. Presumptive Condition(s)" (application page 5) within the last 3 years, you may be eligible for MCHA coverage. Your physician must complete the "Physician's Statement" (application page 5) certifying eligibility and identifying you as having one of the recognized conditions or diagnoses.

*If you are eligible under this category, the effective date of coverage is the date the application and all required documentation and premium is received by MCHA, or if a preexisting condition limitation waiver is requested and approved, the effective date will be backdated to the day following termination of prior coverage. If you choose a date other than the day after termination of prior coverage, the waiver is relinquished and a six-month pre-existing condition limitation will apply to your policy. Refer to the application section "I. Request for Pre-existing Condition Limitation Waiver."*

## Section I. Request for Pre-existing Condition

**Limitation Waiver** [*Required information only if you are applying for eligibility, under section “H. Eligibility” option number 4 (Evidence of Rejection) or option number 5 (Presumptive Condition(s), and requesting a waiver.)*]

If applying for coverage under option 4 or option 5 above, you and your dependent(s) (if added to the policy) are subject to a Pre-existing Condition Limitation. This means that your MCHA policy will not provide benefits for medical expenses incurred during the first six (6) months of coverage for treatment of an injury, illness, or other physical or mental condition (including the provision of prenatal care and maternity related services) if that injury, illness, or condition was diagnosed, treated, or evaluated during the 90-day period immediately prior to the effective date (including treatment with prescription drugs). This rule does not apply to newborns or children placed for adoption who are added to your policy as new dependents after the original effective date of coverage.

Under certain situations you may be eligible for a waiver of the pre-existing condition limitation. This section allows you to apply for a waiver. To be eligible for a waiver you must apply for MCHA coverage within 90 days of termination of your prior coverage and provide the required documentation for review. Application for a waiver does not guarantee the waiver of the pre-existing condition limitation. You will be notified by mail if you have been accepted for coverage, but are not eligible for a waiver of the pre-existing condition limitation.

If you are approved for a waiver of the pre-existing condition limitation, your effective date of coverage will be retroactive to the day after the cancellation date of your previous health coverage. If your pre-existing condition limitation waiver is approved, and you choose to have a different effective date other than the day after the cancellation date of your previous health coverage, you relinquish the waiver of the pre-existing condition limitation (meaning a six-month pre-existing condition limitation will apply to your policy).

## Section J. Applicant’s Disclosure Authorization and Declaration (*Required Information*)

You must initial each section and sign/date the **bold** statement confirming you have read the information.

“Future Effective Date”: You may request a *future* effective date for your MCHA coverage if you choose a date other than the day the completed application is received by MCHA. Indicate in this section the future

date you wish coverage to go into effect. If you are eligible for a pre-existing condition limitation waiver (section “I. Request for Pre-existing Condition Limitation Waiver”), you cannot choose a future effective date and maintain the waiver. Retroactive effective dates cannot be considered unless you apply for and receive approval for a waiver of the pre-existing condition limitation (i.e. retroactive effective date adjusted if a prior coverage annual or lifetime benefit maximum is reached).

## Section K. Premium Payment Options (*Required Information*)

You must indicate how you want to pay your premiums. You have two options:

- **Monthly payments:** For monthly payments, you are required to utilize the Automated Clearing House (ACH) process. This is an automated payment process that will deduct the premium payment from your designated checking or savings account. This withdrawal usually occurs about the 5th day of each month.
- **Quarterly payments:** Quarterly payments are for each calendar quarter (January-March, April-June, July-September, and October-December) and can be made through the ACH deduction process or by receiving a premium statement and mailing in your payment. Premium payments are due the first day of each calendar quarter (January 1st, April 1st, July 1st and October 1st).

For the monthly or quarterly ACH process, complete the “ACH Authorization Agreement.” Attach a voided check or savings account deposit slip to the bottom of page 8 of the application. **A checking account deposit slip is not acceptable.** If ACH premiums will be paid by checking account and voided check is not attached, MCHA will use the submitted premium check account number to set up the ACH process.

You will receive your MCHA premium notice around the 20th day of the month prior to the payment due date.

Whether you choose the monthly or quarterly premium payment option, remember to **include your first premium payment with this application** [coinciding with your choice of monthly (1 month) or quarterly (3 months) payments]. Failure to include the proper premium payment will delay the processing of your application and potentially the effective date of coverage.

Each MCHA policyholder is responsible to make premium payments on behalf of themselves and any dependent(s) covered under the policy. MCHA **does not** accept premium payments or ACH payments from

an employer designated third party administrator.

**Section L. Agent Information** *[Required information to be completed by a Minnesota licensed health insurance agent if you have chosen to apply for coverage with agent assistance or if you are applying under section “H. Eligibility” option number 4 (Evidence of Rejection) and the agent is certifying that you are not eligible for individual health insurance coverage with another health insurance carrier licensed to sell health coverage in Minnesota.]*

If you choose to have assistance from a Minnesota licensed health insurance agent in completing and submitting your MCHA application, the agent will receive a one (1) time \$50 referral fee from MCHA upon acceptance of the application and receipt of the first MCHA premium payment.

Agent Certification of Rejection:

If an agent is certifying your eligibility under section “H. Eligibility” option number 4 (Evidence of Rejection) the agent must fully complete, sign and date this section.

**Section M. Check List**

Review the checklist to help assure all necessary information and documentation is included with your application. Incomplete applications and missing documentation will delay the processing of your application and may possibly affect your effective date of coverage.

**IMPORTANT INFORMATION:**

**Mail the completed application, required documentation and applicable premium to:**

Minnesota Comprehensive Health Association  
Medica  
Mail Route CP382  
401 Carlson Parkway  
Minnetonka, MN 55305-5387

✓ Your first monthly or quarterly premium payment [coinciding with your choice of monthly premium (one month) or quarterly premium (three months) designation] must accompany this application. Refer to the “MCHA Standard/Tobacco-User Premium Rates” sheet to determine the appropriate premium due.

✓ Failure to completely answer all required information and failure to submit all required documentation may delay the processing of your application and the effective date of coverage.

✓ MCHA has 30 days to process your application from the date the completed application, with the required documentation, is received.

**A. Plan Option: *Required Information***

Choose the plan in which you want to enroll:

<input type="checkbox"/> \$500 individual deductible plan	<input type="checkbox"/> High Deductible Health Plan (HDHP) \$3,000 individual/\$6,000 family deductible
<input type="checkbox"/> \$1,000 individual deductible plan	<input type="checkbox"/> \$5,000 individual deductible plan
<input type="checkbox"/> \$2,000 individual deductible plan	<input type="checkbox"/> \$10,000 individual deductible plan

**B. Applicant and Dependent Information (please print): *Required Information***

1. Last Name of Applicant	2. First Name	3. MI	4. Social Security Number

5. If applicant is a minor child, please list parent(s) or legal guardian(s)

6. Age	7. Birth Date (mm/dd/yy)	8. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	9. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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10. Primary Telephone	11. Work Telephone	12. E-mail
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13. Residence Address ( <b>required</b> ):	Number and Street	City	State	Zip
			MN	

14. Optional Address Information (**only if different from residence address above**)  
*Billing Address*

In Care of:	Number and Street	City	State	Zip
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*Claims/EOB Correspondence Address*

In Care of:	Number and Street	City	State	Zip
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15. Dependent Information (list dependent(s) only if you add them to your policy of coverage.) Attach an additional sheet if needed.

	First and Last Name	Male/Female (M) (F)	Birth date	Social Security Number
Spouse				
Child				
Child				
Grandchild				

**C. Residency: *Documentation Required* - You must attach to this application one acceptable form providing proof of Minnesota residency. (Refer to page 2 of the instructions)**

Complete all three (3) questions below:

1. I am a resident of Minnesota. My principal and permanent home is in Minnesota.  Yes  No  
 2. I have been a Minnesota resident for: \_\_\_ Years \_\_\_ Months

**INITIALS:** \_\_\_\_\_

3. My dependent(s) (if listed above) are residents of Minnesota.  Yes  No If "No" list the name(s) and their state of residency.

**D. Tobacco Designation: *Required Information***

Have you or your dependent(s) (if listed above) smoked cigarettes, cigars, a pipe, used chewing tobacco, snuff or nicotine chewing gum, the nicotine patch or other prescription or over the counter smoking cessation products in the 12 months immediately preceding the date of this application?  Yes  No

If you answered "Yes" to the above question, list the names of those individuals to whom this applies:

**INITIALS:** \_\_\_\_\_

**For Internal Use Only**

Effective Date:	Group Acct. #:	Receipt Date:	Processed by:
Check Number(s):	Amount of Premium Rec'd:		

**E. Employment Status: *Required Information***

**You are not eligible for MCHA if your employer offers health coverage to its employees. Minnesota law prohibits employers from encouraging or directing an employee or applicant to apply for MCHA coverage if they are eligible for the employer group plan coverage. Identified cases are reported to the Minnesota Department of Commerce for appropriate action.**

**You must complete the following section:**

- 1. Are you a dependent of an employed person (Refer to page 3 of the instructions for the definition of a dependent)?  Yes  No
- 2. What is your employment status, or if you are a dependent the employment status of your parent/legal guardian or spouse:  
Employed full-time:  Yes  No    Employed part-time:  Yes  No    Self-employed:  Yes  No    Unemployed:  Yes  No
- 3. What is the occupation of employed person: \_\_\_\_\_

a. Identify the name, address, and phone number of the employer or the employed person responsible for the dependent:  
Name: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Address: \_\_\_\_\_

- b. Does the employer currently employ 51 or more employees?  Yes  No
- c. Does the employer offer health coverage to its employees?  Yes  No
- d. Does the employer offer health coverage to the dependents of the employees?  Yes  No
- e. If health coverage is offered, is coverage available through a group policy or an individual plan?  Group  Individual
- f. Are you covered under the employer’s health plan?  Yes  No    If “No”, please explain why: \_\_\_\_\_
- g. Is the dependent covered under the employer’s health plan?  Yes  No    If “No”, please explain why: \_\_\_\_\_
- h. If you are covered under the employer’s health plan, do you have a pre-existing condition limitation period on your policy?  
 Yes  No    If “Yes,” identify when the pre-existing condition limitation will expire: \_\_\_\_\_
- i. If you are covered under the employer’s health plan, do you have a dollar or benefit limitation that has been exceeded?  
 Yes  No    If “Yes,” identify the dollar limit or benefit limitation that has been exceeded and provide documentation from the current health carrier or the employer verifying this information: Dollar limitation (annual or lifetime limit): \_\_\_\_\_  
Benefit limitation (identify the benefit and the limitation): \_\_\_\_\_

**F. Other Health Coverage Information: *Required Information***

**MCHA can not issue this policy if you are age 65 or over and eligible for Medicare Part A and Medicare Part B, or under age 65 and enrolled in Medicare Part A and Medicare Part B. The MCHA deductible plans are not recognized Medicare supplement plans.**

**Are you or any dependent(s) listed in section “B. Applicant and Dependent Information” covered by:**

- 1. Medical Assistance or TEFRA (Tax Equity and Fiscal Responsibility Act)?  Yes  No  
If “Yes”, identify who is covered: \_\_\_\_\_
- 2. General Assistance?  Yes  No    If “Yes”, identify who is covered: \_\_\_\_\_
- 3. Minnesota Care?  Yes  No    If “Yes”, identify who is covered: \_\_\_\_\_
- 4. Medicare?  Yes  No    If “Yes”, identify who is covered and complete a.-d. below:  
\_\_\_\_\_

- a. Effective date of Hospital Insurance (Medicare Part A) \_\_\_\_\_
- b. Effective date of Medical Insurance (Medicare Part B) \_\_\_\_\_
- c. Your Medicare number \_\_\_\_\_

5. Any other current health coverage?  Yes  No    If “Yes,” who is covered? \_\_\_\_\_  
If “Yes,” identify the type of policy:    \_\_\_ Employer group policy    \_\_\_ Individual plan policy

6. Identify your current or most recent health insurance carrier:     Current health carrier     Previous health carrier

a. Name of health insurance carrier:	b. Dates of coverage: From: _____ To: _____
c. Name of policyholder:	d. Phone number of health insurance carrier:
e. Identification number of coverage:	f. Group number (if any):
g. Name of employer providing coverage:	h. Phone number of employer providing coverage:

## G. Reason for Applying for MCHA: *Required Information*

### 1. I am unable to obtain individual coverage because of a health related condition. Yes No

If "Yes" check the box identifying the health condition that prevents you from obtaining coverage. (*This information is confidential and is not be used to determine eligibility.*)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV                 | <input type="checkbox"/> Confidential per previous insurer  | <input type="checkbox"/> Joint disorder                           |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Endocrine disorder (i.e. diabetes) | <input type="checkbox"/> Liver disorder                           |
| <input type="checkbox"/> Arthritis/osteoporosis   | <input type="checkbox"/> Eye/ear condition                  | <input type="checkbox"/> Mental health condition                  |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Gastrointestinal condition         | <input type="checkbox"/> Muscular condition                       |
| <input type="checkbox"/> Back/neck condition      | <input type="checkbox"/> Gynecological/genitourinary        | <input type="checkbox"/> Neurological disorder                    |
| <input type="checkbox"/> Blood disorder           | <input type="checkbox"/> Headaches                          | <input type="checkbox"/> Pregnancy                                |
| <input type="checkbox"/> Breast disease           | <input type="checkbox"/> High cholesterol                   | <input type="checkbox"/> Respiratory disorder                     |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> High cost of medications           | <input type="checkbox"/> Skin disorder                            |
| <input type="checkbox"/> Cardiovascular condition | <input type="checkbox"/> Hypertension                       | <input type="checkbox"/> Weight condition                         |
| <input type="checkbox"/> Chemical dependency      | <input type="checkbox"/> Kidney disorder                    | <input type="checkbox"/> Other (please identify condition): _____ |

**If your dependent(s) are applying for coverage, have they been unable to obtain individual coverage because of a health related condition?**  Not applicable  No  Yes If "Yes", check the box and *list the dependents name* after the primary health condition that prevents them from obtaining coverage.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> AIDS/HIV                 | <input type="checkbox"/> Confidential per previous insurer  | <input type="checkbox"/> Joint disorder                           |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Endocrine disorder (i.e. diabetes) | <input type="checkbox"/> Liver disorder                           |
| <input type="checkbox"/> Arthritis/osteoporosis   | <input type="checkbox"/> Eye/ear condition                  | <input type="checkbox"/> Mental health condition                  |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Gastrointestinal condition         | <input type="checkbox"/> Muscular condition                       |
| <input type="checkbox"/> Back/neck condition      | <input type="checkbox"/> Gynecological/genitourinary        | <input type="checkbox"/> Neurological disorder                    |
| <input type="checkbox"/> Blood disorder           | <input type="checkbox"/> Headaches                          | <input type="checkbox"/> Pregnancy                                |
| <input type="checkbox"/> Breast disease           | <input type="checkbox"/> High cholesterol                   | <input type="checkbox"/> Respiratory disorder                     |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> High cost of medications           | <input type="checkbox"/> Skin disorder                            |
| <input type="checkbox"/> Cardiovascular condition | <input type="checkbox"/> Hypertension                       | <input type="checkbox"/> Weight condition                         |
| <input type="checkbox"/> Chemical dependency      | <input type="checkbox"/> Kidney disorder                    | <input type="checkbox"/> Other (please identify condition): _____ |

### 2. Check the one (1) reason that best describes why you are applying for MCHA coverage:

- MCHA premium rates were less than premium rates quoted to me for a comparable policy in the private market.
- I was unable to afford or to continue to afford my premium rates for continuation coverage.
- I have exhausted my lifetime benefits under my current employer policy. Employer name: \_\_\_\_\_
- I have exhausted my annual benefits under my current employer policy. Employer name: \_\_\_\_\_
- My employer sponsored retiree plan was cancelled, benefits reduced or premiums became unaffordable.  
Employer name: \_\_\_\_\_
- I was unable to continue my health coverage because no continuation was available through my employer.  
Employer name: \_\_\_\_\_
- My employer went bankrupt or went out of business. Employer name: \_\_\_\_\_
- My employer laid me off without the option for continued coverage. Employer name: \_\_\_\_\_
- My employer cancelled its group coverage. Employer name: \_\_\_\_\_
- My insurance company cancelled my individual policy or my employer's group policy.
- I am employed and eligible for group coverage however, I have a pre-existing condition limitation on my policy.  
Employer name: \_\_\_\_\_
- Other \_\_\_\_\_

If you were previously employed, is the employer's group health policy:  Self-Insured  Fully-Insured

(A self-insured employer funds claim payments, and a fully insured employer pays premiums to an insurance company who funds the claim payments).

## H. Eligibility: *Required Information*

Review the eligibility options below **and choose ONLY one (1)**. First, review number “1. Loss of Group Coverage” - all statements must be applicable, checked, and you must include the required documentation. Otherwise, choose an eligibility category from numbers 2-5 below, check the appropriate boxes and include the required documentation.

**Eligibility Part I – No Pre-existing condition Limitation applies to these eligibility categories. The effective date of coverage is the date MCHA receives all necessary information to process the application.**

### 1. **Loss of Group Coverage – Health Insurance Portability and Accountability Act (HIPAA):**

All statements below **MUST** apply and be checked. You **MUST** include a Certificate of Creditable Coverage form showing 18 months of continuous coverage from your previous carrier(s). (Refer to page 3 of the instructions for additional information)

- a) I have elected and exhausted health benefits through COBRA or a similar State or Federal continuation plan, if the option was available. Provide documentation from your previous employer or health insurance carrier stating you have exhausted your continuation rights or documentation stating no continuation coverage was offered.
- b) I have had 18 months of continuous coverage (uninterrupted qualifying coverage) under a health plan, with my most recent coverage being an employer sponsored, church, or government plan (state risk pool plans must be 501c (26) or state’s HIPAA alternative mechanism).
- c) I have had no more than a 63-day break in coverage.
- d) I have not been subject to termination of COBRA coverage because I failed to pay my premium or because I committed acts of fraud.
- e) I am not eligible for Medicare or Medicaid.
- f) I do not have the option of other group health insurance coverage (as a dependent or otherwise).

*If you are seeking a retroactive effective date, to match up with the last day prior coverage ended, you may apply under eligibility options 4 or 5 listed below and you must be approved for a waiver of the pre-existing condition limitation.*

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### 2. **Health Coverage Tax Credit (HCTC) program**

Check the statement that correctly applies to you. You **MUST** include a copy of the HCTC candidate letter.

- a) I am a retiree aged 55 to 64 receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC); or
- b) I am eligible for Trade Adjustment Assistance (TAA) or Alternative Trade Adjustment Assistance (ATAA).

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### 3. **Ineligible for the Federal Medicare program**

You **MUST** include written documentation from Social Security stating that you are not Medicare eligible.

- I have reached age 65 or over and I am not eligible for the health insurance benefits under the Federal Medicare program.

**Eligibility Part II – Generally, a six (6) month pre-existing condition limitation applies to these eligibility categories. However, to request a waiver of the pre-existing condition limitation, refer to section “I. Request for Pre-existing Condition Limitation Waiver” on page 6 of the application. The effective date of coverage is the date MCHA receives all necessary information to process the application, unless a waiver is granted or a future effective date is requested (refer to instructions).**

### 4. **Evidence of Rejection**

Check the statement that applies.

- a) I have received, within the last six (6) months, a rejection or notice of benefit reduction from a health insurance carrier for individual health insurance coverage. You **MUST** submit a dated copy of the insurance carrier denial letter including the name of the health insurance carrier.
- b) I have received a certification of rejection of individual health insurance coverage from a Minnesota licensed health insurance agent. A Minnesota licensed health insurance agent **MUST** complete section “L. Agent Information - Agent Certification of Rejection” of this application (Refer to page 9 of the application).

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### 5. **Presumptive Condition(s)**

Your physician **MUST** complete the “Physician’s Statement” on the next page, to certify that you have a presumptive condition listed in the instructions.

- My health status disqualifies me from coverage in the private market, and I have been treated for one of the medical conditions listed on the next page within the last 3 years.

**H. Eligibility:** Presumptive Condition (s) continued from previous page

Your physician must complete the “Physician’s Statement” certifying eligibility and identifying you have one of the MCHA presumptive conditions or diagnoses listed below:

**Physician’s Statement**

Identify presumptive condition from the list below and last date(s) of treatment: Applicant MUST have been treated within the last 3 years.

Physician’s Name (please print)	Physician’s License Number	Physician’s Signature	Date
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**MCHA Presumptive Conditions**

AIDS/HIV	Leukemia
Alzheimer’s Disease	Malignant Lymphoma
Amyotrophic Lateral Sclerosis (ALS)	Malignant Tumors
Angina Pectoris	Metastatic Cancer
Anorexia Nervosa or Bulimia	Motor/Sensory Aphasia
Aortic Aneurysm	Multiple Sclerosis
Ascites	Muscular Dystrophy
Chemical Dependency	Myasthenia Gravis
Chronic Pancreatitis	Myocardial Infarction
Chronic Renal Failure	Myotonia
Cirrhosis of Liver	Open Heart Surgery
Coronary Insufficiency	Paraplegia
Coronary Occlusion	Parkinson’s Disease
Crohn’s Disease (Regional Enteritis)	Polyarteritis Nodosa
Cystic Fibrosis	Polycystic Kidney
Dermatomyositis	Primary Cardiomyopathy
Friedreich’s Ataxia	Progressive Systemic Sclerosis (Scleroderma)
Hemophilia	Quadriplegia
Hepatitis C	Stroke
History of Major Organ Transplant	Syringomyelia
Huntington Chorea	Systemic Lupus Erythematosus (SLE)
Hydrocephalus	Wilson’s Disease
Insulin Dependent Diabetes	

**I. Request for Pre-existing Condition Limitation Waiver:** Required information when applying for eligibility under “Eligibility Part II”, numbers 4 or 5 on application page 4, and requesting a waiver. Complete this section based on your current or most recent health insurance carrier. If a pre-existing condition limitation waiver is requested and approved, the effective date will be backdated to the day following termination of prior coverage.

- To be eligible for a waiver of the pre-existing condition limitation, you must apply for MCHA coverage within 90 days of the termination date of your prior coverage.
  - Check one box below.
  - Completion of this information does not guarantee a waiver of the pre-existing condition limitation. You will be notified by mail of the status of your waiver request.
1. My employer terminated coverage without offering continuation coverage. Provide documentation from your past employer or health insurance carrier identifying the cancellation date and the reason coverage was terminated.
  2. I have exhausted my continuation coverage under COBRA or other continuation coverage under a similar state law. Provide documentation from your past employer or health insurance carrier stating you have exhausted your continuation rights. Identify the effective date and cancellation date of your prior coverage and current paid-to-date of your continuation policy.
  3. I was terminated or laid off (voluntarily or involuntarily) from employment and I am unable to exercise my option to continue my fully-insured group continuation coverage. This waiver applies to continuation coverage under Minnesota (MN) State law and does not apply if your most recent coverage was under a self-funded federal COBRA (Consolidated Omnibus Budget Reconciliation Act) plan. This waiver applies to continuation coverage due to termination or lay-off from employment and not to continuation coverage due to other qualifying events such as employee disability, dependent reaching the limiting age, divorce, or employee reaching Medicare age. Provide documentation from your past employer identifying the cancellation date of your coverage and verifying your employer coverage was a fully insured plan.
  4. I was terminated or laid off (voluntarily or involuntarily) from employment and I am unable to exercise my option to continue my group coverage. Provide documentation from your past employer identifying the cancellation date and the reason continuation coverage was not available.
  5. I was covered by an employer retiree plan and the coverage is no longer available. Provide documentation from your past employer identifying the cancellation date and reason coverage was terminated.
  6. My previous coverage was provided by a rehabilitation facility and coverage was terminated. Provide documentation from rehabilitation facility identifying the cancellation date and reason the coverage was terminated.
  7. I was covered under a conversion policy and I cancelled the coverage. Provide documentation from your previous health insurance carrier confirming your previous coverage was a conversion policy and the cancellation date.
  8. My health insurance carrier terminated my group health insurance coverage. My coverage was not terminated because I failed to pay premiums, or because I voluntarily terminated coverage, or because I provided materially false statements or misrepresented myself in my terminated policy application. Provide documentation from your previous health insurance carrier identifying the cancellation date and the reason coverage was terminated.
  9. My health insurance carrier terminated my individual health insurance coverage. My coverage was not terminated because I failed to pay premiums, or because I voluntarily terminated coverage, or because I provided materially false statements or misrepresented myself in my terminated policy application. Provide documentation from your previous health insurance carrier identifying the cancellation date and reason the coverage was terminated.
  10. My previous coverage ended due to insolvency of the health insurance carrier. Provide documentation from your previous health insurance carrier identifying the date your benefits were exhausted.
  11. I have exceeded the lifetime maximum benefit under my previous coverage. Provide documentation from your previous health insurance carrier identifying the date your benefits were exhausted.
  12. I have exceeded the annual maximum benefits under my current coverage. Provide documentation from your health insurance carrier identifying the date your annual maximum benefit(s) were met.
  13. I was enrolled in Medical Assistance, General Assistance Medical Care, or MinnesotaCare program and coverage was terminated. Provide documentation from the applicable program identifying the cancellation date from the program.

**Initial one of the statements below:**

If the waiver of pre-existing condition is approved, I understand my effective date of coverage will be to the day after the cancellation date of my previous health coverage. I agree to pay all MCHA premiums as of this effective date of coverage.

**INITIALS:** \_\_\_\_\_

Or

I have reviewed the above list of waiver exceptions and I am not seeking a waiver of the Pre-existing Condition Limitation. I understand that a six (6) month Pre-existing Condition Limitation will be applied to my policy.

**INITIALS:** \_\_\_\_\_

**J. Applicant's Disclosure Authorization and Declaration: *Required Information***

I represent that no person named is currently covered by an MCHA policy; that the foregoing statements and answers are complete, accurate, and true and that any coverage issued will be in full reliance upon this representation; and I understand and agree that no coverage shall be effective until all requirements have been completed, received and approved by MCHA. I further acknowledge that any inaccurate, false, or fraudulent statements may lead to rescission of coverage issued.

INITIALS: \_\_\_\_\_

I understand and agree that referring agents are not authorized to interpret, amend, or alter the terms of the MCHA insurance policy, nor are referring agents authorized to bind MCHA in any way.

INITIALS: \_\_\_\_\_

I understand that MCHA has 30 days to process this enrollment form. Coverage shall be effective the date MCHA receives all materials necessary to constitute a completed enrollment form, including the appropriate premium payment, unless otherwise noted and initialed in section "I. Request for Pre-existing Condition Limitation Waiver" or in section "J. Applicant's Disclosure Authorization and Declaration - "Future Effective Date" (bottom of this page)."

INITIALS: \_\_\_\_\_

I hereby authorize and request any hospital, clinic, institution, physician, or other person to furnish MCHA or its writing carrier full details of diagnosis, treatment, medical history, and any other information and conclusions about me and any member of my family, and to accept as valid a photocopy of this authorization and my signature. I understand that MCHA keeps this information confidential, but may release it if I authorize release, or under circumstances where state or federal law permits or requires release without authorization, including release to an entity with which MCHA or its writing carrier has contracted for disease management services. For purposes of obtaining information in connection with this application, reinstatement, or change in policy benefits, this release is valid for as long as I remain continuously insured by MCHA. I understand that I am entitled to receive a copy of this release. I understand that I may revoke this authorization by providing written notice to MCHA or its writing carrier. I understand that if I revoke this authorization, this may affect enrollment for me or my dependents.

INITIALS: \_\_\_\_\_

I authorize any insurance company, institution, employer, or person that has my records or knowledge of my health history or that of any of my family members for whom insurance is requested to give such information to MCHA or its writing carrier. I understand that a reproduction of this authorization shall be as valid as the original. I understand that information obtained will remain subject to the protections of Health Insurance Portability and Accountability Act's privacy standards.

INITIALS: \_\_\_\_\_

The information I provide on this form and any attachment is private data under Minnesota law. By providing this data, I authorize MCHA and its writing carrier to use and disclose the data to determine my eligibility for the state plan. The law does not require me to provide any data, but my failure to do so will result in my loss of eligibility for the state plan. Any data I provide may also be made available to the employees, agents, directors, or officers of MCHA or its writing carrier. It may also be made available to peer review panels or consultants, contributing members of MCHA, nurse line or disease management entities, hospitals, doctors, and other health care providers involved in my care, health plans and similar entities responsible for payment of my care, the Minnesota Commerce Department, actuarial or research organizations, or other persons authorized by law to receive such data. Unless revoked, this authorization remains in effect as long as I remain continuously insured by MCHA.

INITIALS: \_\_\_\_\_

**I have read the above statements; I agree to supply the data on this form with full knowledge of the information provided in these statements.**

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Applicant Date Signature of Parent Date  
(if applicant is under age 18)

**Future Effective Date (Not available if a waiver of the pre-existing limitation is granted)**

I choose a future effective date other than the day the completed application and necessary documentation was received.

Yes  No

- If "Yes", specify the requested future effective date: \_\_\_\_\_
- If you have applied under the Health Insurance Portability Accountability Act (HIPAA), refer to "Section H. Eligibility" option "1", the future effective date can not exceed 63 days from the date of termination of prior coverage.

INITIALS: \_\_\_\_\_

## K. Premium Payment Options: *Required Information*

Will you have assistance from an organization or employer to pay MCHA premiums?  Yes  No If "Yes", identify the organization or employer that will assist you:

Department of Human Services (DHS)  American Kidney Fund  Other \_\_\_\_\_

Employer/Address/Phone # \_\_\_\_\_

Choose one premium payment option: (Refer to the Instructions for additional information.)

**Monthly premium payment.** You are required to use the ACH payment process for monthly billing.

**ACH Payment.** See ACH Payment Process described below; **or**

Health Coverage Tax Credit (HCTC) program recipients (see section "H. Eligibility, option "2".) must choose the monthly premium payment option if coordinating premium credits with HCTC. The ACH payment process will not apply. For the HCTC monthly credit, send your monthly MCHA premium invoice to HCTC.

**Quarterly premium payment. Choose one of the following options:**

**ACH Payment.** See ACH Payment Process described below; **or**

**Payment by check.** A check for the full quarterly premium (3 months) is due on the first day of each calendar quarter (January through March, April through June, July through September, and October through December). Payment should be by personal check, business check, money order or cashier's check.

**Note:** Whether you choose the monthly or quarterly premium payment option, remember to attach your first premium payment with this application [a month's premium (1 month) or a full quarter's premium (3 months) per your elected payment option above]. You must submit your first premium payment with this application or your application will be considered incomplete and will be returned to you. **The premium payment should be made payable to "MCHA."**

### ACH Payment Process:

For the monthly or quarterly ACH process, complete the "ACH Authorization Agreement" below and attach a voided check or savings account deposit slip below. **A checking account deposit slip is NOT acceptable.**

<b>ACH (Automated Clearing House) Authorization Agreement</b>			
The Minnesota Comprehensive Health Association (MCHA) through its administrator, Medica, is hereby authorized to deduct my MCHA premium payment due them by electronic debit entries from my checking or savings account indicated below.			
Name of Account Holder			
Bank Name			Account Type ( <i>check one</i> ): <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Bank Address	City	State	Zip Code
<b>Signature of Account Holder(s):</b>			
Account Holder Name (Print)		Account Holder Name (Print)	
X _____		X _____	
Account Holder Signature	Date	Account Holder Signature	Date

**ATTACH A VOIDED CHECK OR  
SAVINGS ACCOUNT DEPOSIT SLIP HERE**  
A checking account deposit slip is NOT acceptable

**L. Agent Information:** *Required information for agent assisted applications*

The Minnesota licensed agent of record receives a one (1)-time \$50 referral fee from MCHA upon acceptance of the application and receipt of the first premium payment.

1. Name (please print):	2. MN Health Insurance License No. and Expiration Date:
3. Issue Payment to (if different then above)	4. Tax ID or Social Security Number:
5. Street Address:	6. Telephone:
7. City, State, Zip Code:	8. E-mail: Fax:
9. Agent's Signature: <i>Murray Herstein</i>	10. Date:

**Agent Certification of Rejection:** *Required information if applicant is applying under section "H. Eligibility: 4.Evidence of Rejection" item "b."*

1. Reason for rejection or medical condition:

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2. Name and Address of Insurer or Health Maintenance Organization (HMO) licensed to sell health coverage in Minnesota that will NOT accept the applicant:

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3. I am an insurance producer licensed by the Minnesota Department of Commerce. I certify that the information I have provided is true and correct and I understand that the Minnesota Comprehensive Health Association (MCHA) will rely upon the information I have provided in determining whether or not the applicant is eligible for coverage.

**AGENT INITIALS:** \_\_\_\_\_

Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**M. Check List:** *Required Information*

**Incomplete applications will be delayed and the effective date may change if all required information and documentation is not received. All applicable questions must be answered, all required documentation must be included and applicable premium payment must be included for an application to be considered complete.**

- I have chosen a "Plan Option" (see instructions for section A).
- I have attached documentation verifying that I have an address and residence in Minnesota for the six (6) month period preceding application to MCHA (see instructions for section C).
- I have completed the "Tobacco Designation" section (see instructions for section D).
- I have attached the required documentation needed for eligibility (see instructions for section H).
- If requesting a waiver of the six (6) month pre-existing condition limitation, I have applied for and have attached the required documentation proving eligibility for a waiver (see instructions for section I).
- I have read and signed the "Applicant's Disclosure Authorization and Declaration" section (see instructions for section J).
- I have enclosed a check or money order payable to MCHA for a month's premium (1 month) or a full quarter's premium (3 months), (per my elected payment option), and if electing ACH, completed the "ACH Authorization Agreement" and have attached a voided check or savings account deposit slip (see instructions for section K).
- I have completed all required applicable sections.
- I have read and initialed all items noted by "Initial: \_\_\_\_\_."
- If applying under section "H. Eligibility" reason "1. Loss of Group Coverage," I have enclosed a Certificate of Creditable Coverage form showing 18 months of continuous coverage from my previous health insurance carrier(s).
- If applying under section "I. Request for Pre-Existing Condition Limitation Waiver" reason "2. I have exhausted my continuation coverage under COBRA or other continuation coverage," I have enclosed documentation from my past employer or health insurance carrier stating I have exhausted my continuation rights.

Checklist is completed by: \_\_\_\_\_ X \_\_\_\_\_ Date \_\_\_\_\_  
Print Name Signature

**Failure to completely answer all questions and to submit required documentation may delay the processing of your application or the date your coverage becomes effective.**  
**Your full premium payment must accompany this application.**

