



HEALTH PLAN COMMUNITY

2018 McLaren Health Plan Individual Application (Off Marketplace Only)

Thank you for your interest in **McLaren Health Plan (MHP)** individual health plans!

MHP Individual coverage is a package of affordable, comprehensive HMO plans designed for individuals and families who are looking for health coverage options. Members must live in the areas MHP Individual coverage is offered, and cannot have health insurance through an employer or government-sponsored program.

The first step to becoming an MHP Individual member is to complete this application by answering all questions, signing the application and sending it to McLaren Health Plan Community, Attention: Sales Department, G-3245 Beecher Rd. Flint, MI 48532. You will receive notification within one to two weeks on the status of your application.

Paper applications must be received by the 15th of the month to be eligible for coverage on the first of the following month. Please complete the attached application for MHP Individual coverage. This form is a legal document and must be completed in its entirety so that you and your family receive proper and timely coverage. An incomplete application will delay the application process and access to medical benefits. Please complete this form per the following instructions:

Application Information – Primary Applicant

This section is to be completed for the primary applicant. Complete all applicable blank spaces.

Applicant Information – List all Individuals applying for coverage

In the spaces provided, indicate name, gender, birth date and social security number of all applicants. If you are requesting coverage for more than four dependent children, please include their information on a separate page.

Plan Coverage Selection

Please indicate your choice of benefit plan by checking the appropriate box.

Payment Options¹

Please indicate if you would like to have your ongoing monthly premium deducted by Electronic Fund Transfer (EFT), or if you wish to receive a coupon booklet. If you wish to enroll in EFT, please complete the Electronic Payment Consent Form and return it with your application. You will receive confirmation from us informing you of the first date the EFT will begin. Funds will be transferred from your account on the first day of the month. If you do not elect EFT, your first month's premium must accompany your application for coverage.

¹The first month's premium is due with the application. Your application will not be processed until we receive your first month's premium.

Terms, Conditions and Authorization

Please read this section carefully before signing the application. The application must be signed and dated by the applicant, spouse, and any dependent children age 18 or older.

Non-Tobacco Use Affidavit

You are a "non-tobacco user" if you are not currently using, and have not used during the previous 30 days, any tobacco products, including cigarettes, cigars, chewing tobacco, pipe tobacco, snuff, dip, e-cigarettes or any similar tobacco-related product. For the purpose of this program, tobacco products do not include nicotine patches, nicotine gum or other items that are considered primarily tobacco cessation aids. If you have any questions, please contact Customer Service at (888) 327-0671.

Agent/Agency Verification

This section is to be completed by the Agent, if applicable.

Note: If you have any questions about this application or the process, call us at (888) 327-0671 or contact your agent.



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Mail completed application to: McLaren Health Plan Community
G-3245 Beecher Rd. Flint, MI 48532

Questions? Call (888) 327-0671
Fax: (810) 733-9596

Coverage and Enrollment

Who will be covered by this plan?

One adult (individual plan)
 Multiple people (family plan)
 Child only

Why are you applying?

Open Enrollment (November 1, 2017 to December 15, 2017); or
 I have a qualifying event (*choose one*):
 Marriage
 Birth
 Loss of other coverage

 Other – please explain: _____

Applicant Information – Primary Applicant

Applicants Name:			Member ID:	Effective Date:
Street Address	City	State	Zip Code	County
Home Phone Number ()	Work Phone Number ()	Mobile Phone Number ()		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Do you reside in Michigan nine or more months each year? <input type="checkbox"/> Yes <input type="checkbox"/> No An applicant must reside in the McLaren service area nine or more months each year to qualify.			
Are all applicants United States citizens or have a valid social security number? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Applicant Information – List all individuals applying for coverage (up to age 26)

Name (Last, First MI)	Gender	Birthdate (mm/dd/yyyy)	SS# <small>(you must supply this unless a child is less than 90 days old)</small>	Primary Care Physician	Tobacco Usage
Primary Name:	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N
Spouse Name:	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N
Name: <input type="checkbox"/> Dependent Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Disabled Dependent*	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N
Name: <input type="checkbox"/> Dependent Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Disabled Dependent*	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N



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Continued, Applicant Information - List all individuals applying for coverage (up to age 26)

Name: <input type="checkbox"/> Dependent Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Disabled Dependent*	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N
Name: <input type="checkbox"/> Dependent Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Disabled Dependent*	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N

* Disabled Dependent: Please complete the Disabled Dependent Form on page 9 and 10 of this packet.

Plan Coverage Selection

For plan details please visit McLarenHealthPlan.org

Please select the plan you wish to enroll in.

<input type="checkbox"/> McLaren Silver Standard \$4,000/\$8,000 Deductible, 30% Coinsurance Total Out of Pocket Max \$7,350/\$14,700	<input type="checkbox"/> McLaren Bronze Standard \$5,550/\$11,000 Deductible, 50% Coinsurance Total Out of Pocket Max \$7,350/\$14,700
<input type="checkbox"/> McLaren Gold Marketplace Standard \$1,400/\$2,800 Deductible, 20% Coinsurance Total Out of Pocket Max \$5,000/\$10,000	<input type="checkbox"/> McLaren Silver Marketplace Standard \$3,500/\$7,000 Deductible, 20% Coinsurance Total Out of Pocket Max \$7,350/\$14,700
<input type="checkbox"/> McLaren Individual Catastrophic (Off Marketplace) \$7,350/\$14,700 Deductible, Total Out of Pocket Max \$7,350/\$14,700	<input type="checkbox"/> McLaren HSA Bronze (Off Marketplace) \$6,550/\$13,100 Coinsurance after Deductible 100% Total Out of Pocket Max \$6,550/\$13,100



HEALTH PLAN COMMUNITY

ELECTRONIC PAYMENT CONSENT FORM

Date: _____

Member ID #: _____

Phone #: _____

Member Name: _____

Address: _____

I, _____ (Print

Name) give permission for the McLaren Health Plan (MHP) Community Finance Department to electronically withdraw the amount owing for the monthly premium payment from the bank account shown below. I certify that I am a legal signer on the bank account indicated and can authorize this type of payment. This withdrawal will be completed on a monthly basis in accordance with the date indicated below. If there are not sufficient funds available on the date of withdrawal to complete this transaction, I understand that I am liable to complete the monthly payment premium in another manner. MHP Community reserves the right to revoke this agreement at any time.

Bank Name: _____

Bank Routing #: _____

Bank Account #: _____

Month of first electronic withdrawal for: Checking _____ **OR** Savings: _____

Signature: _____

[MHPCC20140606-APP Rev. 10/11/17]



HEALTH PLAN COMMUNITY

ELECTRONIC BILL PAYMENT PLAN

The MHP Community electronic funds transfer (EFT) payment plan, for collecting monthly health insurance premiums, will be administered in the following manner:

- On the first business day of every month, the amount indicated on your monthly coupon will be automatically debited from your designated checking (or savings) account.
- MHP Community must be notified of any changes to your designated checking (or savings) account at least 15 days prior to the last day of the month. If there are insufficient funds in your account for the electronic funds transfer to occur you are responsible for any bank fees charged to MHP Community. You will also be responsible for payment of the monthly premium in another manner. MHP Community will only attempt the electronic funds transfer once a month, on the first business day of the month.
- Please fill out all information and sign the attached form. Mail, fax or email the form to the following:

**Attn: Finance Dept.
 McLaren Health Plan Community
 G-3245 Beecher Road
 Flint, MI 48532**

Fax: (810) 733-9652

Email: MHPFinanceDepartment@mcclaren.org

- A letter will be sent to you by mail to confirm the receipt of your request for electronic bill payment deductions. This letter will also confirm the date your first payment will be withdrawn from your account. Please continue to make your regular monthly payments until you receive the confirmation letter.

If you have any questions regarding the electronic payment of your monthly billing statements, please call the finance department at (810) 733-9682.

Payment Options

- Electronic funds transfer (EFT): Please complete section below.
- Coupon booklet

The first month's premium is due with the application. Your application will not be processed until we receive your first month's premium.

[MHPCC20140606-APP Rev. 10/11/17]



HEALTH PLAN COMMUNITY

Application–MHP Individual Health Plan

Applicant Name:

[Empty text box for Applicant Name]

Terms, Conditions and Authorizations

By completing and signing this application for individual health insurance coverage, I agree to the following:

- 1. All information I have provided on this form is true to the best of my knowledge and belief and correctly recorded by me.
2. Any material misstatement in this application may result in denial of a claim and/or rescission of coverage.
3. The effective date of coverage will be on the 1st of the month following approval by MHP Community.
4. I certify that I meet all requirements for eligibility stated within this application including but not limited to:
a. Michigan residency for nine or more months during the year.
b. United States Citizen or have a valid social security number.
c. No other health insurance coverage currently in place, except Medicaid.

Authorization to Send Email Messages

Periodically MHP Community sends out emails to our members providing them a newsletter, or to send information alerts/notifications or administrative reminders. MHP Community will not sell or give away your email information.

I authorize MHP Community to send periodic emails to me at the email address I have provided. I understand I may open emails on my cell phone and that charges from my cell phone provider may apply. MHP Community is in no way responsible for any fees charged to me by my cellular provider. I understand email is not a secure form of communication. If after receiving such emails, I wish not to receive them in the future, I may opt out of this program.

Email address: _____

Applicant's Signature: _____

- 1. No contract waiver, modification or change of contract shall be binding upon MHP Community unless it is in writing and signed by an authorized officer of MHP Community.
2. I represent that neither I, my spouse, nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer.
3. I understand and agree that no agent, producer or broker has the authority: (i) to bind MHP Community by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information MHP Community requests; (iii) approve coverage; (iv) make or alter any contract on behalf of MHP Community; (v) waive or alter any of MHP Community's other rights or requirements.
4. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not provide interim coverage.
5. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not provide interim coverage.



HEALTH PLAN COMMUNITY

Non-Tobacco User Affidavit

Table with 3 columns: Last Name, First Name, Middle Initial, Member ID, Home Phone, Work Phone

A tobacco user is defined as any person using a tobacco product, other than for religious or ceremonial use, four or more times per week within the past six months. Tobacco products include cigarettes, cigars, chewing tobacco, snuff and pipe tobacco.

Please check only ONE of the following choices:

Member

Input box for Member choice

I am a non-tobacco user and, therefore, entitled to avoid the tobacco premium surcharge.

Spouse

Input box for Spouse choice

I am a non-tobacco user and, therefore, entitled to avoid the tobacco premium surcharge.

You are a "non-tobacco user" if you are not currently using, and have not used during the previous 30 days, any tobacco products, including cigarettes, cigars, chewing tobacco, pipe tobacco, snuff, dip, e-cigarettes or any similar tobacco-related product. For the purpose of this program, tobacco products do not include nicotine patches, nicotine gum or other items that are considered primarily tobacco cessation aids. If you have any questions, please contact Customer Service at (888) 327-0671.

Member

Input box for Member choice

I do not qualify as a non-tobacco user and agree to pay the tobacco premium surcharge.

Spouse

Input box for Spouse choice

I do not qualify as a non-tobacco user and agree to pay the tobacco premium surcharge.

By my signature below, I certify that:

- All of the information I have provided on this affidavit is true and correct; and
I understand that any misrepresentation of information on this certificate will subject me to the requirement to pay the tobacco surcharge for the current plan year; and
I further understand that dishonesty or misrepresentation of information on this certificate may result in revocation of coverage.

Member Signature

Today's Date

Spouse Signature

Today's Date

[MHPC20141204]



HEALTH PLAN COMMUNITY

I have personally read, understand and agree to the terms, conditions and authorization listed throughout this application.

Applicant's Signature

Date Signed

Spouse's Signature

Date Signed

Signature of Child age 18 Years or Older

Date Signed

Signature of Parent/Legal Guardian for Child(ren)

Date Signed

Agent/Agency Verification

All questions on this application have been completed by the applicant and the responses are true and accurate to the best of my knowledge.

Signature of Agent *		Date	
Name of Agent (<i>print name</i>)			
Agent/Agency Number			
Address	City	State	ZIP
Phone Number		Fax Number	
Email Address			

Note: Agent must contract with and be designated by MHP Community. Call Sales Support at (888) 327-0671 for further information.



HEALTH PLAN COMMUNITY

DEPENDENT UNDER A QUALIFIED MEDICAL CHILD SUPPORT ORDER OR “QMCSO”

ELIGIBILITY

The child must:

- be under 26 years old; and
- be under court or administrative order (QMCSO) stating that his or her medical care is the Subscriber’s; or Subscriber’s spouse’s legal responsibility.

Note: A copy of the QMCSO is required to enroll the child.

ENROLLMENT

The child may be enrolled at any time, preferably within 30 days of the date of the QMCSO.

In addition:

- If the Subscriber/spouse does not apply, the child may be enrolled by the Friend of the Court or by the child’s other parent or guardian through the Friend of the Court.
- The Subscriber parent may change from individual Coverage to family Coverage.
- If the parent that is required under the QMCSO to provide coverage for the child is not already a Subscriber or Member, that parent may enroll (if eligible) when the child is enrolled.
- Neither parent may disenroll the child from an active contract while the QMCSO is in effect, unless the child becomes covered under another plan, premiums have not been paid as required by the agreement, or the child is no longer eligible as a Covered Dependent.

EFFECTIVE DATE OF COVERAGE

- If MHP Community receives notice within 30 days of the QMCSO, coverage is effective as of the date of the QMCSO.
- If MHP Community receives notices after 30 days of the QMCSO, coverage is effective on the date MHP Community receives notice.

In order for MHP Community to make determination, please provide the following information:

Subscriber Information

Name: _____

Date of Birth: _____ Marital Status _____

Full Address: _____

Gender: _____ Home Phone: _____

Day Phone: _____

Dependent Information

Name: _____

Social Security Number: _____ Date of Birth: _____ Gender: _____

Marital Status: _____ Relationship to Subscriber: _____

Full Address: _____

[MHP20141222]



HEALTH PLAN COMMUNITY

Disabled Dependent Form

- A. Does the dependent reside with you?
B. Does the dependent rely on you for more than half of their support?
C. Is the dependent capable of self-sustaining employment?
D. Is the dependent currently receiving Social Security benefits?
E. Is the dependent covered by Medicare?

Treating Physician Information

Physician Name Group Physician
Street Address City State Zip Code

- A. How long have you been treating the dependent?
B. What is the dependent's diagnosis or diagnoses which cause them to be disabled?
C. Did the disability exist prior to the dependent reaching the age of 26?
D. When was the disability diagnosed?
E. Is the disability temporary or permanent?

Additional information

Please give MHP Community a letter with the following information signed by the treating physician: the dependent's diagnosis, the signs and symptoms of the condition, whether the dependent is capable of being self-supporting and if not, why the dependent is incapable of self-support.

Verification

The information I have given is true to the best of my knowledge. I have given MHP Community all of the necessary and requested information. I know that my dependent's coverage may be denied if I have not given MHP Community all of the needed information or if I have given MHP Community the wrong information.

Subscriber's Signature

Date Signed

[MHP20141222]



HEALTH PLAN COMMUNITY

INDIVIDUAL PEDIATRIC ESSENTIAL HEALTH BENEFIT ACKNOWLEDGEMENT

Applicant Name:

The undersigned Applicant understands that certain pediatric dental benefits are among the 10 categories of essential health benefits (EHBs) required under the Patient Protection and Affordable Care Act (PPACA). A failure to provide pediatric dental EHBs could result in the Applicant being non-compliant under PPACA. Applicant also understands that Qualified Health Plans (QHPs) purchased through MHP Community do not include the pediatric dental EHBs needed to comply with PPACA requirements and that they must be purchased through Delta Dental or through another carrier.

Applicant certifies that he/she either purchased the required pediatric dental EHB through Delta Dental, or a separate qualified dental plan that covers the required pediatric dental care through another carrier.

Applicant Signature

Date:

Are you using an Agent? Yes No

If Applicant has an Agent, Agent must complete the additional attestation:

As agent for the Applicant, in addition to the statement above, I also certify that this customer has purchased the pediatric dental essential health benefits needed to comply with PPACA requirements. I understand that failure to adhere to this certification can result in termination of my contract with MHP Community; nonpayment of commissions; or other penalties identified by MHP Community.

Agent Signature

Date

Agent Name (*print*)

Date

[MHPCC11199762]