2017 McLaren Individual Application
(off exchange)

Thank you for your interest in ***McLaren*** individual health plans!

McLaren 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 McLaren Individual coverage is offered, and cannot have health insurance through an employer or government-sponsored program.

The first step to becoming a McLaren 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 McLaren 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 appropriate box.

Other Insurance Information
Please indicate yes or no to all of the questions in this section. For any 'yes' responses, please fill in the requested information in the space provided.

Payment Options[1]
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 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.

[1]***The 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.

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

Tobacco Usage
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.

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

McLaren Individual (off exchange) Application

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

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

Applicants Name: _____ Requested Effective Date: _____

Applicant Information – Primary Applicant				
Street Address	City	State	Zip Code	County
Home Phone Number ( )	Work Phone Number ( )		Mobile Phone Number ( )	
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Do you reside in Michigan nine or more months each year? ☐ Yes ☐ 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? ☐ Yes ☐ No				

Applicant Information – List all individuals applying for coverage (up to age 26)					
Name (Last, First, MI)	**Gender**	**Birth date** (mm/dd/yyyy)	**SS#** *(you must supply this unless a child is less than 90 days old)*	**Primary Care Physician**	**Tobacco Usage**
Primary Name:	☐ M ☐ F				☐ Y ☐ N
Spouse Name:	☐ M ☐ F				☐ Y ☐ N
Name: ☐ Dependent Child ☐ Stepchild ☐ Disabled Dependent*	☐ M ☐ F				☐ Y ☐ N
Name: ☐ Dependent Child ☐ Stepchild ☐ Disabled Dependent*	☐ M ☐ F				☐ Y ☐ N
Name: ☐ Dependent Child ☐ Stepchild ☐ Disabled Dependent*	☐ M ☐ F				☐ Y ☐ N
Name: ☐ Dependent Child ☐ Stepchild ☐ Disabled Dependent*	☐ M ☐ F				☐ Y ☐ N
* Disabled Dependent: Please complete the Disabled Dependent Form on page 8 and 9 of this packet					☐ Y ☐ N

Continued

McLaren HEALTH PLAN

Plan Coverage Selection	
Coinsurance: A percentage of the cost of covered services you will pay after your deductible has been met.	
Deductible: A fixed dollar amount you must pay each benefit year before certain services are covered by the plan. Some services are not subject to deductible	
Please select the plan you wish to enroll in.	
☐ McLaren Rewards Platinum (off exchange) $500/1000 Deductible, 10% Coinsurance Total Out of Pocket Max $1250/2500	☐ McLaren Rewards Gold (off exchange) $1400/2800 Deductible, 25% Coinsurance Total Out of Pocket Max $4800/9600
☐ McLaren Gold Standard (off exchange) $1250/2500 Deductible, 20% Coinsurance Total Out of Pocket Max $4750/9500	☐ McLaren Silver Standard (off exchange) $3500/7000 Deductible, 20% Coinsurance Total Out of Pocket Max $7150/14300
☐ McLaren Bronze (off exchange) $6000/12000 Deductible, 40% Coinsurance Total Out of Pocket Max $7150/14300	☐ McLaren Individual Catastrophic (off exchange) $7150/14300 Deductible, Total Out of Pocket Max $7150/14300

ELECTRONIC PAYMENT CONSENT FORM

Date: _____

Member ID #: _____

Phone #: _____

Member Name: _____

Address: _____

_____

I, _____ (Print Name) give permission for the McLaren Health Plan 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. McLaren Health Plan Community reserves the right to revoke this agreement at any time.

Bank Name: _____

Bank Routing #: _____

Bank Account #: _____

Month of First Electronic Withdrawal:

_____ Checking _____Savings

Signature _____

ELECTRONIC BILL PAYMENT PLAN

The McLaren Health Plan Community (MHP Community) electronic funds transfer 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.

- McLaren Health Plan 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 McLaren Health Plan Community. You will also be responsible for payment of the monthly premium in another manner; McLaren Health Plan 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:

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

  F**ax: (810) 733-9652**

  Email: rebecca.tower@mclaren.org

- A letter will be sent in the mail confirming receipt of your request for electronic bill payment deductions to be made from your designated bank account on a monthly basis. This letter will also confirm the date that your first payment will be deducted 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) 733-9528.

McLaren HEALTH PLAN

Application – McLaren Individual Health Plan

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. Once the application is submitted, I may be contacted by phone or e-mail by McLaren Health Plan Community (MHP Community) or its representative to complete the application process.
3. The effective date of coverage will be on the 1st of the month following approval by MHP Community. Evidence of approval will be based upon the issuance of ID cards and policy certificate. Coverage is contingent upon the timely and accurate premiums due and will be terminated if this condition is not met.
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: _____

5. 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.
6. I represent that neither I, my spouse, nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer.
7. 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.
8. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not provide interim coverage.
9. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not provide interim coverage.

McLaren HEALTH PLAN

Non-Tobacco User Affidavit

Member ID	Home Phone	Work Phone
Last Name	First Name	Middle Initial

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

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

Spouse

☐ **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, and 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

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

Spouse

☐ **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]

McLaren HEALTH PLAN

Applicant Name:

An eligible individual may enroll during Open Enrollment or upon a qualifying event. If this is a qualifying event please check one of the following:

☐ Marriage ☐ Birth ☐ Loss of Other Coverage ☐ Other Please Explain: _____

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 *(Print Name)*	
Agent/Agency Number	
Street Address of Mailing Address	
Phone Number	Fax Number
Email Address	

**** Note:** Agent must contact with and be designated by McLaren Health Plan Community in order to receive a commission. Call Sales Support at (888) 327-0671 for further information.*

Disabled Dependent Form

1.03 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/Subscriber spouse parent 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: _____

continued

A. Does the dependent reside with you? ☐ Yes ☐ No

B. Does the dependent rely one you for more than half of their support? ☐ Yes ☐ No

C. Is the dependent capable of self- sustaining employment? ☐ Yes ☐ No

   a. Currently employed? ☐ Yes ☐ No

D. Is the dependent currently receiving Social Security benefits? ☐ Yes ☐ No

   a. How many months as the dependent been receiving benefits? _____

E. Is the dependent covered by Medicare? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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. This information must appear on the physician or medical group's letterhead and be signed and dated by the physician. MHP Community reserves the right to request more information regarding the dependent, including but not limited to medical records.

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 give MHP Community the wrong information. MHP Community may request more information to decide if my disabled dependent may be covered.

_____ _____

Subscriber's Signature Date Signed

[MHP20141222 p.2/2]

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 McLaren Health Plan Community (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]

McLaren Health Plan (McLaren) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. McLaren does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

McLaren:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact McLaren's Compliance Officer.

If you believe that McLaren has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with McLaren's Compliance Officer, G-3245 Beecher Rd., Flint, MI 48507, call: (866) 866-2135, TTY 711, Fax: (877) 733-5788, or Email mhpcompliance@mclaren.org.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, McLaren's Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-327-0671 (TTY: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-327-0671 (رقم هاتف الصم والبكم: 711).

Syriac/Assyrian:
ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܐܝܬܠܘܢ ܕܡܩܒܠܝܬܘܢ ܡܢ ܚܕܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1-888-327-0671 (TTY: 711)

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-327-0671（TTY：711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-327-0671 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-327-0671 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-327-0671 (TTY: 711)번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-888-327-0671 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-327-0671 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-327-0671 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-327-0671 (TTY: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-327-0671（TTY:711）まで、お電話にてご連絡ください。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-327-0671 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-327-0671 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-327-0671 (TTY: 711).